Exhibit 3

Advanced
DOCUMENT & HANDWRITING
EXAMINATION SERVICES, LLC

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Linda James, B.C.D.E., Diplomate

January 6, 2020

TO: Schell, Cooley, Ryan, Campbell, LLP
Attorney Kristin Mijares
5057 Keller Springs Road
Suite 425
Addison, TX 75001

SUBJECT: Civil Action No.: 4:18-cv-00615-alm; *Meier, et al v. UHS of Delaware, Inc., et al*; In the United States District Court, Eastern District of Texas, Sherman Division.

REQUESTED ANALYSIS: To determine if any of the Plaintiffs' Alleged Medical Records identified as "inconsistencies"/ "forgeries"/ "alterations" are genuine or non-genuine for the following subjects:

1. Dr. Sabahat Faheem
2. Madison Paige Hough
3. Yolanda McPherson
4. Tiffany Young

EVIDENCE RECEIVED: The following list of documents submitted to me for the sole purpose of this examination has been grouped according to the subjects listed above for easy reference, and attached hereto as **Exhibit A**:

1. Regarding *Dr. Sabahat Faheem*: Multiple medical record files via PDF

ADHES Reference	Questioned	Date	Copy or Original
SF-Q1	Mayhill Hospital Physicians Orders - 1 page - Signature - Bates No. Mayhill MH000047	03/27/17 04/10/17	Copy

ADHES Reference	Known *Submitted as genuine signatures of Dr. Sabahat Faheem*	Date	Copy or Original
SF-K01	Physician Discharge Order - 1 page - Signature - Bates No. Mayhill MH000028	03/27/17	Copy
SF-K02	Suicide Behaviors Questionnaire-Revised (SBQ-R) - 1 page - Signature - Bates No. Mayhill MH000039	03/25/17	Copy
SF-K03	Treatment plan for Madison Hough - 1 page - Printing and Signature - No Bates number	03/28/17	Copy
SF-K04	Mayhill Hospital Admitting Patient Medication Orders for Madison Hough - 1 page - Signature - No Bates number	03/25/17	Copy
SF-K05	Schryver Medical Laboratory report - 1 page - Initials - No Bates number	03/27/17	Copy

2. Regarding *Madison Paige Hough*: Medical records file via PDF (Bates No. Mayhill MH000001-128)

ADHES Reference	Questioned	Date	Copy or Original
MH-Q1	Patient's Bill of Rights - 2 initials - 1 signature - Bates No. Mayhill MH000022	03/24/17	Copy

ADHES Reference	Known *Submitted as genuine signatures of Madison Paige Hough*	Date	Copy or Original
MH-K01	Request for Release - 1 signature - Baes No. Mayhill MH000002	03/27/17	Copy
MH-K02	Request for Discharge/AMA Questionnaire - Handwriting - Bates No. Mayhill MH000003	03/27/17	Copy
MH-K03	Handwriting on lined paper - 3 pages - 1 signature - Bates No. PLTF 027366-027368	08/30/18	Copy
MH-K04	HIPAA Privacy Authorization Form - 2 pages - Handwriting and Signature - Bates No. PLTF 003348-003349	09/13/17	Copy
MH-K05	Request writing on lined paper during deposition - 1 page - 4 signatures - Depo Exhibit No. 7 - No Bates number	10/15/19	Copy

3. Regarding *Yolanda McPherson*: Medical records file via PDF (Bates No. Millwood YM000001-227)

ADHES Reference	Questioned *Regarding Yolanda McPherson*	Date	Copy or Original
YM-Q1	Consent for Treatment - 2 pages - Printed name and signatures - Bates No. PLTF 004409-4410	01/23/18	Copy
YM-Q2	Consent to Release Information - 2 pages - Handwriting, initials and signature - Bates No. PLTF 004411-4412	01/23/18	Copy
YM-Q3	Understanding and Helping the Suicidal Individual - 1 page - Signature - Bates No. PLTF 004433	01/31/18	Copy
YM-Q4	My Safety Crisis Plan - 1 page	01/24/18	Copy

	- Handwriting and Signature - Bates No. PLTF 004435		
YM-Q5	Aftercare Plan/Instructions - 1 page - Signature - Bates No. Millwood YM000003	01/31/18	Copy
YM-Q6	Continuing Care Discharge Plan Order Form… - 1 page - Printed name and Signature - Bates No. Millwood YM000004	01/31/18	Copy

ADHES Reference	**Known** *Submitted as genuine signatures of Yolanda McPherson*	**Date**	**Copy or Original**
YM-K01	Enlarged signature on a form with typed words "Thiebaud Remington Thornton Bailey, LLP - 1 page - Signature - No Bates No.	08/21/19	Copy
YM-K02	HIPAA-Compliant Authorization to Disclose Patient-Identifiable Health Information - 1 page - Signature - Bates No. PLTF 017726	08/21/19	Copy
YM-K03	CareFlite Patient Care Record - 1 page (page 4 of 9) - Electronically signed - Bates No. PLTF 027113	01/23/18	Copy
YM-K04	IRS Form 4506 - 1 page - Handwriting and Signature - Bates No. PLTF 011750	02/12/19	Copy

4. Regarding *Tiffany Young*: Medical records file via PDF (Bates No. Hickory TY000001-166)

ADHES Reference	**Questioned** *Regarding Tiffany Young*	**Date**	**Copy or Original**
TY-Q1	Hickory Trail Hospital Patient Rights: Consent to Treatment with Psychoactive Medication - 1 page - Signature - Bates No. Hickory TY000016	11/05/17	Copy

ADHES Reference	Known *Submitted as genuine signatures of Tiffany Young*	Date	Copy or Original
TY-K01	Pet Therapy Program Consent Form - 1 page - Signature - Bates No. Hickory TY000017	11/05/17	Copy
TY-K02	Hickory Trail Hospital Financial Agreement - 1 page - Handwriting and signature - Bates No. Hickory TY000019	11/05/17	Copy
TY-K03	IRS Form 4506 - 1 page - Handwriting and signature - Bates No. PLTF 011749	02/21/19	Copy
TY-K04	HIPAA-Compliant Authorization to Disclose Patient-Identifiable Health Information - 1 page - Signature - Bates No. PLTF 011804	02/21/19	Copy
TY-K05	Authorization for Release of Employment Records - 1 page - Signature - Bates No. PLTF 011805	02/21/19	Copy
TY-K06	Ketamine of North Texas, LLC | policy form - 1 page (2 of 7) - Initials and signature - Bates No. PLTF 013101	01/15/19	Copy
TY-K07	Ketamine of North Texas, LLC | Patient's Rights and Responsibilities - 2 pages - Signature - Bates No. PLTF 013102-013103	01/14/19	Copy
TY-K08	Disclosure and Concent for Medical Procedures - 1 page - Signature - Bates No. PLTF 013104	01/15/19	Copy
TY-K09	Ketamine of North Texas, LLC | Ketamine Treatment Discharge Instructions - 1 page - Signature - Bates No. PLTF 013096	01/15/19	Copy

NOTE: The numbers assigned to each document are hereby adopted by reference as if fully set out herein. The description(s) are noted as best as possible based upon the information found on the document(s) submitted.

QUALIFICATIONS: The most current Curriculum Vitae is attached hereto as **Exhibit B**.

I am board certified by the National Association of Document Examiners as a forensic document examiner. I have maintained my board-certified qualifications for twenty-three years. In 2005, I earned the title Diplomate. On January 1, 2016, I was recertified by the National Association of Document Examiners. I have attended and received certificates of completion from 57 continuing education conferences since 1990. Additionally, I hold certificates from the following: the American Institute of Applied Science, the North Central Texas Council of Governments, the National Questioned Document Association, and the College Notre-Dame-de-Foy in Canada.

I presently hold and/or have held the following positions with the following associations: President of the National Association of Document Examiners, 2017-2020; Certification Chairperson of the National Association of Document Examiners, 2014-2017; President of the National Association of Document Examiners, 2009-2013; 1st Vice President of the National Association of Document Examiners, 2005-2009; Certification Committee for the National Association of Document Examiners, 2000-2009; By-Laws Chairman of National Association of Document Examiners, 2000-2005; Secretary of Association Certified Fraud Examiners, Dallas, Texas, 2001-2002; Associate Director of Association Certified Fraud Examiners, Dallas, Texas, 1998-1999.

I have extensive training and experience in forensic document examination. I am state licensed to instruct law enforcement and private investigators in forensic document examination techniques. I have presented 47 lectures on forensic document examination issues, which are listed on my Curriculum Vitae. My presentations and writings have been peer-reviewed on numerous occasions.

I have served as an instructor on document examination for the following: the Texas Board of Private Investigators and Private Security Agencies, the Texas Commission of Law Enforcement Officer Standards and Education, the Association of Certified Fraud Examiners, and the National Questioned Document Association. Three document and handwriting examiners have been mentored by me.

My articles on document examination have been published in the National Association of Document Examiners Journal. A list of my publications can be found in my Curriculum Vitae.

My Curriculum Vitae lists my court experience, including numerous cases in which I have testified as an expert in Forensic Document Examination. I have been retained as an expert in Forensic Document Examination by and have testified for both plaintiffs and defendants in civil cases and probate cases. I have been retained as an expert by the State of Texas in criminal cases through the Smith County District Attorney's Office, the Hays County District Attorney's Office, the San Jacinto County District Attorney's Office, and the Ellis County District Attorney's Office and Dallas County District Attorney's Office and District Attorney's Office in the state of Kansas and Louisiana. I have been retained as an expert by the Federal Public Defender's Office in the Northern District of Texas, State Counsel for Offenders-A Division of Texas Department of Criminal Justice, United States Department of Justice, and United States Navy and United States Army.

I have been a court-appointed expert in civil and/or criminal cases in United States District Court of the Northern District of Texas, Dallas and Fort Worth Division; Federal Public Defender from Dallas, Texas; Las Vegas, Nevada; Wainwright, Alaska, Albuquerque, New Mexico. I have been a court-appointed expert in civil and/or criminal cases with court appointed attorneys in the following counties in Texas: Bell, Bernalillo, Bexar, Brazos, Brazoria, Collin, Cooke, Dallas, El Paso, Grayson, Harris, Hays, Hunt, Jefferson, Lamar, McLennan, Medina, Nueces, Tarrant, Parker, Wichita Falls, and in the state of Alabama and Kansas. Additionally, I have been successfully qualified as an expert in Forensic Document Examination under the specific Daubert/du Pont guidelines. My opinions have never been excluded under Daubert/du Pont guidelines. Since I was board certified in 1995, I have never been disqualified as a Forensic Document Examination expert in any case.

COMPENSATION:

I am being paid my customary hourly rate of $150.00 for studying various documents and providing any opinions regarding examinations of handwritten documents for authorship.

PRIOR EXPERT TESTIMONY:

A list of courts where I have testified for the past four years; is attached hereto as **Exhibit C.1**.

A list of depositions where I have testified for the past four years; is attached hereto as **Exhibit C.2**.

METHODOLOGY:

When conducting an examination of the documents submitted to me for comparison in this matter, I relied on the accepted methodology in the field of forensic document examination, which includes comparing "unknowns" to "knowns" (whether the "known" and "unknown" subject matter be signatures, words, letters, dates, etc.), to see whether there is an agreement between either of them.

In order to see if there is an agreement between the "known" and "unknown" subject matters, an independent study of the handwriting characteristics and combination of those handwriting characteristics are made in each of them first. This study allows the examiner to learn the writing patterns used to form letters, the patterns of movement, proportions of letters and/or within the patterns, size relationships, spatial patterns, slope, directional tendencies, initial strokes, terminal strokes, connecting patterns, curvatures, speed of execution, quality of execution, and any other graphic patterns present.

Once the independent studies of the "known" and "unknown" subject matter are made and noted, a comparison between the handwriting characteristics and combination of those handwriting characteristics are made.

This methodology for examining the authorship of handwritten documents has been accepted since at least 1922 and accredited to Albert Osborn in his book *Questioned Documents*. It is accepted as appropriate in the field of forensic document analysis and is generally used by forensic analysts around the country, including police and government analysts. This method of comparison for Examination of Handwritten Items are available through the Scientific Working Group for Document Examiners (SWGDOC).

Testimony based on this methodology is routinely relied upon by forensic document examiners, including police and government analysts, and has been regularly admitted in court around the country.

EXAMINATION CONDUCTED: The following steps were employed for each one of the four subjects listed above:

Once the documents were received, an examination of the documents was conducted. In doing this, I relied on the accepted methodology in the field of forensic document examination, which begins with an independent study of the handwriting characteristics found in the **questioned** (unknown) signatures. It includes, but not limited to, the handwriting characteristics such as shapes, size, slope, speed, proportions, baseline, line quality, beginning and ending strokes, the simplified or complex nature of the signature(s), writing movement, tempo, patterns, letter definition or lack thereof, placement, horizontal expansion, and range of natural variation.

The same independent study was made of the handwriting characteristics found in the **known** signatures.

A comparison of the handwriting characteristics was then made between the **questioned** and **known** signatures in order to determine whether or not there was a common writer.

Additionally, all documents have undergone objective and multiple forensic examination processes using optical aids pertinent to the examination such as enlargements and side-by-side comparisons. The unique and individual handwriting characteristics and range of variation of the letter forms for each writer was assessed throughout the signatures.

APPLIED HANDWRITING PRINCIPLES: An expert must adhere to the standard principles of his/her trade. The following are some of those applied to this specific case:

1) The principles of handwriting identification are based on the comparison of certain distinctive characteristics imprinted in the individual writing. These characteristics are made involuntarily and cannot be completely suppressed or concealed by the writer. They are highly personal and individual.[i]
2) A series of fundamental agreements identifying individualities is requisite to the conclusion that two or more writings were authored by the same person. It is the combination of these individualities with their accumulative significance in a handwriting which serves to identify the writer.[ii]

3) Be it remembered that the identification of an individual's writing does not depend on the nature of any one of the characteristics found in his handwriting, but in the peculiar combination of the characteristics.[iii]

4) The evidence of identity or non-identity must be cumulative, and the force and proof depend not on any single coincidence varying materially, but upon the fact that all characteristics in their individual strength weighed collectively must produce a definite conclusion. Whether two writings agree or differ, the identification or distinction cannot be decided by one single characteristic, however significant that factor may appear.[iv]

5) In every instance of a disputed document controversy, the evidence of identity or non-identity must be cumulative, and the force and proof depend not on any single coincidence varying materially, but upon the fact that all characteristics in their individual strength weighed collectively must produce a definite conclusion. Whether two writing agree or differ, the identification or distinction cannot be decided by one single characteristic, however significant that factor may appear.[v]

6) The important and unappreciated fact is that the variations in a handwriting are themselves habitual. When all brought together and carefully examined show running through them a marked, unmistakable individuality.[vi]

7) If the several signatures under investigation show natural variations of writing of the same word or letter, all of course within the scope of variation of the genuine writing, this variation itself, is strong evidence of genuineness.[vii]

8) When the range of variation of the letter forms for a writer is assessed throughout many standards, a likeness of each letter within that range will stand out to mark the letters as the work of one writer.[viii]

9) Variation does not preclude identification of the writing. In fact, variation around the basic qualities of the handwriting forms an additional factor that serves to personalize and identify writing.[ix]

10) If the several signatures under investigation show natural variations of writing of the same word or letter, all of course within the scope of variation of the genuine writing, this variation itself, is strong evidence of genuineness.[x]

11) A widely divergent master pattern can properly be considered to be a "personal" characteristic of the handwriting in which it occurs.[xi]

12) Abbreviated, distorted and illegible forms, which are sufficiently free and rapid, often actually indicate genuineness rather than forgery even though they are very unusual and not exactly like those in the standard writing. When writing shows by any quality or in any way that it is the result of unconscious habit this always is a forceful indication of genuineness. This quality is shown by repeated significant characteristics executed with ordinary attention to the operation as indicated by incompleteness, illegibility, natural variation, and carelessness.[xii]

OBSERVATIONS AND RESULTS OF ANALYSIS:

The following observations are grouped according to the subjects listed:

1. Regarding *Dr. Sabahat Faheem*:

This writer has more than one style, therefore it is important to examine many exemplars to see fuller range of variation in the first and last name when applying forensic methods for comparing handwriting characteristics.

The signature is written with the first initial and last name. The capital letter 'S' is written with a slight curl at the beginning of the letter and that section is larger than the lower section on most exemplars.

The capital letter 'F' has an exaggerated hook before it continues down to the baseline making it appear like a lowercase printed 'f' and it is the tallest letter of the whole signature. The lowercase 'a' is written with an elongated oval. When the signature is a shorter style, the lowercase 'aheem' are connected and written without much definition almost in a threading style that ends above the baseline and out to the right. This style is found on **SF-Q1** and some of the **known** signatures.

2. Regarding *Madison Paige Hough*:

This writer exhibits many unusual individual characteristics in the first and last name when applying forensic methods for comparing handwriting characteristics.

The capital 'M' starts out to the left close to the base line before it continues upward creating the left stem, retracing itself to create the cup and second vertical stem that is also retraced. This letter simulates a capital 'U' letter. The lowercase 'a' is written with an opening at the top of the letter. The lowercase 'd' has a tiny loop and a short vertical stem. The lowercase 's' is written larger than the other lowercase letters and touches/overlaps the next letter. The final stroke in the lowercase 'n' ends straight down.

The second vertical stem in the capital 'H' is longer than the first vertical stem. The lowercase 'ou' is joined together and simulates a lowercase 'w' that floats above the baseline. The lowercase 'g' is written entirely above the baseline. The final stroke in the lowercase 'h' ends straight down much like the lowercase 'n' in the first name.

Overall, the signature is written in a print-script style. This means some letters are printed while others are cursive. The combination of these characteristics along with their variations that are also found in the **known** signatures. In addition, they appear to be written with the same tempo, pattern, naturalness, and writing style which also indicates there is one writer.

3. Regarding *Yolanda McPherson*:

This writer exhibits a highly stylized signature that has individual characteristics and is difficult to simulate when applying forensic methods for comparing handwriting characteristics.

The capital 'Y' is written with a very large cup / loop and overlaps the following letter(s) in the **question** signatures as well as the **known** signatures. The lowercase 'o' is written under the capital 'Y' and is written with an extremely narrow (sometimes retraced) oval. The lowercase 'd' has many different exaggerations of the same movement. At times, the loop of the 'd' can be very small and sits midway up the vertical stem and other times it can encompasses the lowercase 'lan' letters before it connects to the last letter. This variation is seen in all of the **question** signatures as well as the **known** signatures.

The capital ‘M’ has a lead in stroke that forms a shallow cup and finishes with the last vertical stem reaching below the baseline. The ‘c’ is written up close to the top of the capital ‘M’ almost as if floating. The capital ‘P’ has a small, cupped lead in stroke. The vertical stem and cup of the capital ‘P’ is written like a large bubble that encompasses part of the capital ‘M’ and the superscript/floating ‘c’ before it connects to the following letter. The lowercase ‘herson’ letters are written in cursive and is connected to each other meaning the pen does not pick up in the process.

The combination of these identifying individual characteristics along with their variations that are found in **questioned** signatures are also found in the **known** signatures. In addition, they appear to be written with the same tempo, pattern, naturalness, and writing style which also indicates there is one writer.

4. Regarding *Tiffany Young*:

This writer exhibits a wide range of variation as seen in her **known** writing samples, yet they also share critical identifying features when applying forensic methods for comparing handwriting characteristics.

The first name on the **TY-Q1** signature is printed. The horizontal crossbar on the capital ‘T’ is long, wavy and sits just above the vertical stem. The two lowercase ‘ff’ are printed and look similar to a candy cane with horizontal crossbars about halfway up the stem. The second ‘f’ horizontal crossbar connects to the following lowercase letter ‘a’. There is space between the vertical stem of the lowercase ‘y’ and the cup. The vertical stem of the lowercase ‘y’ ends just below the baseline. A variation of these individual characteristics can be found within the **known** exemplars.

The last name on the **TY-Q1** signature is written in cursive. There is a large capital ‘Y’ and the lowercase ‘oung’ is written without much detail in a threaded like pattern. The lowercase ‘g’ ends with a large oval loop. A variation of these individual characteristics can be found within the **known** exemplars.

There are a series of fundamental agreements and identifying individual characteristics found within the **TY-Q1** signature. It is the combination of these characteristics along with their variations that are also found in the **known** signatures. In addition, they appear to be written with the same tempo, pattern, naturalness, and writing style which also indicates there is one writer.

STATEMENT OF OPINIONS: The following opinions, rendered with scientific certainty, are based on the examination of documents submitted to me, the application of the handwriting principles given in this report, my experience and training as a forensic document and handwriting examiner, and in accordance with the accepted methodology in the field of forensic document examination.

1. Regarding *Dr. Sabahat Faheem*:

It is my professional opinion there are handwriting characteristics that agree between **SF-Q1** and the known signatures indicating there is one writer. For attorneys it is equal to "reasonable grounds for suspicion." Due to the fact that the quality of copy submitted for examination is a poor production and there are not more signatures for comparison allowing me to see all the different styles this writer uses, it is more appropriate for the opinion of indication did pen the questioned signature.

2. Regarding *Madison Paige Hough*:

It is my professional opinion that it is highly probable that **MH-Q1** is authentic. An opinion of highly probable is next to the highest degree of confidence expressed by document examiners in handwriting comparisons. Highly probable is next to the highest degree of confidence expressed by document examiners in handwriting comparisons. For attorneys it is equal to "proof by clear and convincing evidence."

3. Regarding *Yolanda McPherson*:

It is my professional opinion that it is highly probable that the **YM-Q1** through **YM-Q6**, are authentic. An opinion of highly probable is next to the highest degree of confidence expressed by document examiners in handwriting comparisons. Highly probable is next to the highest degree of confidence expressed by document examiners in handwriting comparisons. For attorneys it is equal to "proof by clear and convincing evidence."

4. Regarding *Tiffany Young*:

It is my professional opinion that **TY-Q1** is probably genuine. This opinion is rendered with probability, meaning that more likely than not that the questioned signatures and known signatures were written by the same individual. For attorneys it is equal to "proof by preponderance of the evidence."

This report may be supplemented later if I have an opportunity to examine the original document of the photocopied document reviewed to date or if any future requests are made concerning this case and/or if additional documents are later submitted for comparison.

HANDWRITING OPINION TERMINOLOGY:

Attached as **Exhibit D** to this report is a copy of the Standard Terminology for Expressing Conclusions of Forensic Document Examiners from the Scientific Working Group for Forensic Document Examination (SWGDOC).

Respectfully submitted,

Linda James

Linda James

Forensic Document & Handwriting Examiner

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[i] *Law of Disputed and Forged Documents*, Baker, J. Newton
[ii] *Evidential Documents*, Conway, James V. P.
[iii] *Law of Disputed and Forged Documents,* Baker, J. Newton
[iv] *Law of Disputed and Forged Documents,* Baker, J. Newton
[v] *Law of Disputed and Forged Documents,* Baker, J. Newton
[vi] *Questioned Document*s, Osborn, Albert
[vii] *Questioned Document*s, Osborn, Albert
[viii] *Fundamentals of Document Examination,* Robertson, Edna W.
[ix] Hilton
[x] *Questioned Document*s, Osborn, Albert
[xi] Harrison
[xii] *Questioned Document*s, Osborn, Albert

EXHIBIT LIST

A: Evidence Received and Examined

1. Dr. Sabahat Faheem
2. Madison Paige Hough
3. Yolanda McPherson
4. Tiffany Young

B: Statement of Qualifications

C: Prior Expert Testimony

1. Court Testimony
2. Deposition Testimony

D: Handwriting Opinion Terminology

EXHIBIT A

EVIDENCE RECEIVED AND EXAMINED

EXHIBIT A.1

EVIDENCE RECEIVED AND EXAMINED

Dr. Sabahat Faheem

Mayhill Hospital **PHYSICIANS ORDERS**

DATE	TIME	Additional Orders: *(Dates/Times Required)*
3/25/15	9:00am	Patient refused to take any psychotropic medications to address mood /
		noted [illegible]
		1345 3/25/17 S. Faheem MD
3-27-17	0535	24° [illegible]
Late entry:		
3-27-17	1345	Place pt on 24° hold. Allow social services to meet with parents in Intake.
		TORB Dr. Faheem/Ellis RN
		[illegible] 4/01/17 @ 08[illegible]
		S. Fah[illegible]

Weight	Height	Allergies & Sensitivities □ NKA	Diagnosis

HOUGH, MADISON 018
M# 000010684 04/25/1998
A# 81072350010 03/25/2017
UNITED BEHAVIORAL

Mayhill Hospital

PHYSICIAN DISCHARGE ORDER

Discharge Patient To:

☐ Home	☐ RTC	☐ Nursing Home	☐ PHP →	Projected Start Date: _____
☐ ALF	☐ Group Home	☐ Hospital	☐ IOP →	Projected Start Date: _____
☐ Court			☐OPS →	Projected Start Date: _____

☐ Continue all non psychiatric medications as listed on the MAR

☐ Number of antipsychotic medication at discharge: _____

If two or more antipsychotics, please identify rationale

☐ Three or more previously failed trials of monotherapy.

Medications involved in Failed Trials: 1. _____ 2. _____ 3. _____

☐ Tapering to monotherapy or cross-taper in progress. _____

Medications to taper or cross-taper: _____

☐ Augmentation of clozapine with additional medication(s).

☐ Patient to follow D/C Safety Plan

☐ Tobacco Cessation Medication Recommendation: _____

☐ Additional Physician Instruction to Patient: _____

☐ Patient may take home all medications brought from home except: _____

Activity Restrictions: ☐ Yes ☐ No Diet: ☐ No Restrictions ☐ Special Diet

Final Diagnosis:

Psychiatric/Substance Use Diagnoses: 1) MDD R/S w/o psychosis

2) Marijuana abuse

Personality Disorder and Intellectual Diagnoses: deferred

Medical Diagnoses: none

Psychosocial Diagnoses: poor support

Physician Signature: S. Fahn M.D Date: 3/27/17 Time: 9am

Nursing Signature: _____ Date: _____ Time: _____

HOUGH, MADISON 018
M# 000010684 04/25/1998
A# 81072350010 03/25/2017
UNITED BEHAVIORAL HEALTH

PH-03 03/2016

Suicide Behaviors Questionnaire-Revised (SBQ-R)

Evaluation of Suicide Risk for Clinicians

Questions to assess thoughts of suicide

1. Have these symptoms/ feelings (of depression) we've been talking about led you to think you might be better off dead?
   ☑ Yes ☐ No
2. This past week, have you had any thoughts that like is not worth living or that you'd be better off dead?
   ☑ Yes ☐ No
3. What about thoughts about hurting or even killing yourself? (if "yes", go to question 4. If "No", stop.
   ☑ Yes ☐ No
4. What have you thought about? Have you actually done anything to hurt yourself?
   ☐ Yes ☐ No

Risk Factors for Suicide (VERDICT UTHSCSA)

___ **Hopelessness**	___ **Prior Suicide Attempts**	___ **Substance Abuse**
___ Caucasian Race	___ Family Hx of Suicide Attempts	___ Medical Illness
___ Male Gender	___ Family Hx of Substance Abuse	___ Psychosis
___ Advanced Age	___ **Access to Means**	
___ Living Alone	___ Other :	

Assessment of Suicide Risk and Action Plan

Description of Patient Symptoms	Level of Risk	Action	Check
No current thoughts; no Major Risk Factors (bolded)	Low	Continue to monitor, follow-up and Assess	
Current thoughts, but no plans; with or without Major Risk Factors and pt able to contract for safety	Intermediate	Assess suicide risk carefully at each visit. Contract for safety with patient. Patient to agree to report if thoughts become more prominent. Determine level of monitoring.	
Current passive thoughts, with plan; Patient is able to contract for safety while in hospital, no current means	High	Assess suicide risk carefully at each visit. Contract for safety with patient. Patient to agree to report if thoughts become more prominent. Determine level of monitoring.	
Current active thoughts with plans; possible current means, unable to contract for safety	☑ High	Assess for placement on 1:1 monitoring or other precautions for safety. Re-assess daily.	

Physician Signature S. Faheem M-D Date / Time 3/25/17

Suicide Risk as designated by the faculty and staff of South Texas Veterans Healthcare S
Health Care Service Center. (VERDICT UTHSCSA) Permission granted by John Williams, Jr

HOU H, MADISON 018
M# 00010684 04/25/1998
A# 1072350010 03/25/2017
UNI ED BEHAVIORAL HEALTH
DR. S. FAHEEM F IPL

ADHES
SF-K03

ADHES
SF-K04

Mayl ospital

Medication Reconciliation and Physician Medication Admission Orders

Admitting Nurse or Physician Lists the Home Medications and Indicates Yes to Order or No to Discontinue

Brought in & Verified	Home Medication	Dose	Frequency	Route	Last Dose	Continue	If Yes – Indication If No – Justification for Discontinuation
□ Yes □ No						□ Yes □ No	
□ Yes □ No						□ Yes □ No	
□ Yes □ No						□ Yes □ No	
□ Yes □ No						□ Yes □ No	
□ Yes □ No						□ Yes □ No	
□ Yes □ No						□ Yes □ No	
□ Yes □ No						□ Yes □ No	
□ Yes □ No						□ Yes □ No	
□ Yes □ No						□ Yes □ No	
□ Yes □ No						□ Yes □ No	

ADDITIONAL ADMISSION MEDICATION ORDERS

Medication	Dose	Frequency	Route	Orders	Indication
				□ New □ Revised	
				□ New □ Revised	
				□ New □ Revised	
				□ New □ Revised	
				□ New □ Revised	
				□ New □ Revised	
				□ New □ Revised	
				□ New □ Revised	
				□ New □ Revised	
				□ New □ Revised	

Nurse Signature: [signature] Date: 3/4/17 Time: 2200

Physician Signature: S. Faheem M.D. Date: 3/25/17 Time: 9:00 am

~~Mayhill Hospital~~
Admitting Patient Medication Orders

HO H, MADISON 018
M# 00010684 04/25/1998
A# 1072350010 03/25/2017

ADHES
SF-K05

Schryver Medical Laboratory

866-776-5221

Patient:	**Patient Date of Birth:**	**Physician:** FAHEEM, SABAHAT
Schryver Patient ID:	**Patient Age and Sex:**	**Location:**Mayhill Hospital Floor 1
Client Patient ID:	**Fasting:** Unknown	**Room Number:**
Order ID: 4868-10-17083		

Culture, Urine
Specimen ID: E170830233
Prelim, Updated Result - Received 03/26/2017 8:59AM MDT

Lab: SM_Euless[1]
Approving Tech:
Collected: 03/24/2017 4:00AM MDT

Test	Result	Unit	Ref Range
PRELIM 2	MICROBIOLOGY RESULTS		

SPECIMEN TYPE
CLEAN CATCH

URINE CULTURE RESULT:

PRELIMINARY SETUP REPORT: 3/24/2017,4:18 PM CULTURE HAS BEEN SETUP.

PRELIMINARY REPORT 1: 3/25/2017,9:05 AM
CULTURE IN PROGRESS, FURTHER INCUBATION REQUIRED.

PRELIMINARY REPORT 2: 3/26/2017,9:57 AM
ISOLATE: GRAM POSITIVE COCCI ISOLATED. COLONY COUNT 50,000 - 99,000.
ID AND SENSITIVITY TO FOLLOW.
ISOLATE: YEAST ISOLATED. COLONY COUNT 50,000 - 99,000 . NO FURTHER TESTING PERFORMED.

TSH With Reflex To FT4
Specimen ID: D170830153
Pending

Lab: SM_Denver[2]
Approving Tech:
Collected: 03/25/2017 4:23AM MDT

S-F
3/27/17 9a

Report Creation: 03/26/2017 8:59AM MDT

Reporting Laboratories:

(1) SM_Euless (CLIA ID: 45D1027949), 310 S. Industrial Blvd, Suite 100, Euless, TX 76040, 866-776-5221

(2) SM_Denver (CLIA ID: 06D0986268), Lab Director: MARTINCHICK, JAMES, 12075 E. 45th Ave, Suite 700, Denver, CO 80239,

EXHIBIT A.2

EVIDENCE RECEIVED AND EXAMINED

Madison Paige Hough

Mayhill Hospita
BEHAVIORAL HEALTI

PATIENT'S BILL OF RIGHTS

When you apply for or receive mental health services in the State of Texas, you have many rights. Your most important rights are listed on these four (4) pages. These rights apply to all persons unless otherwise restricted by law or court order. A judge or lawyer will refer to actual laws. If you want a copy of the laws from which these rights come from, you can call the Health Facility Licensure and Compliance Division of the Texas Department of State Health Services (888) 973-0022.

It is the responsibility of this hospital, under law, to make sure you have been informed of your rights. But just giving you this information does not mean your rights have been protected. This hospital is required to respect and provide for your rights in order to maintain licensure and to conduct business in this state.

Your Right to Know Your Rights

You have the right, under the rules by which this hospital is licensed, to be given a copy of these rights, before you are admitted to the hospital as a patient. If you so desire, a copy should also be given to the person of your choice. If a guardian has been appointed for you, or you are under 18 years of age, a copy will also be given to your guardian, parent, or conservator.

You also have the right, to have these rights explained to you aloud in simple terms in a way you can understand within 24 hours of being admitted to the hospital to receive services (e.g., in your language if you are not English-speaking, in sign language if you are hearing impaired, in Braille if you are visually impaired or other appropriate methods).

Your Right to Make a Complaint

You have the right to make a complaint and to be told how to contact people who can help you. These people and their addresses and phone numbers are listed below.

You have the right to be told about Advocacy, Inc., when you first enter the hospital and when you leave. Information about how to contact Advocacy, Inc. is also listed below.

As a patient, *you are responsible for the following*:

1. To provide accurate and complete information about present complaints, past illness, hospitalizations, medications and other matters relating to you health and reporting whether you clearly understand your treatment plan. Also to report unexpected changes in your condition to your physician or member of health care team. **2.** To follow the treatment plan recommended by your physician and to express any concerns you may have about your ability to follow a proposed course of treatment. This will include following the instructions of nurses and other health care personnel as they carry out the coordination plan of care implement your physician's orders and enforce the applicable hospital policies. **3.** For asking questions if you do not understand any instructions you are given. **4.** For the outcomes if you refuse treatment or refuse to follow instructions. **5.** For following the hospital polices affecting patient care and conduct. **6.** For being considerate of the rights of other patients and hospital personnel, and for assisting in control of noise and the number of visitors. **7.** Providing information for insurance and working with the hospital to arrange payment, when needed.

If you believe your rights have been violated or you have other concerns about your care in this hospital, you may contact one or more of the following: **Mayhill Hospital Patient Advocate (940) 239-3000**

Health Facility Licensure and Compliance Division **Texas Department of State Health Services** **1100 W. 49th Street, Austin, Texas 78750**	**(888) 973-0022** **(800) 735-2989 (TDD Phone Number)**
Consumer Services and Rights Protection **Texas Department of State Health Services** **P.O. Box 12668, Austin, Texas 78711-2668**	**(800) 252-8154**
Advocacy, Inc. **7800 Shoal Creek Blvd., Suite 171 E., Austin, Texas 78757**	**(800) 880-2884** **(512) 454-4816**
Joint Commission on Accreditation of Healthcare Organizations (JCAHO) **1 Renaissance Blvd. Oak Brook Terrace, Illinois 60181**	**(800) 994-6610**

If you have been involuntary admitted and you believe that your attorney did not prepare your case properly or your attorney failed to represent you point of view to the judge, you may wish to report the attorney's behavior to the Ethics Committee of the State Bar of Texas by writing:

Disciplinary Council
State Bar of Texas
6300 La Calma Dr., Suite 300, Austin, Texas 78752

If you are a voluntary patient OR if you have been taken to the hospital against your will, turn to pages three and four (3-4) for a listing of your special rights under law in Texas. All patients should read pages two and three (2-3), which explain the rights that apply to everyone receiving services at this hospital.

I agree that:

MH (Initial) I received a copy of this document prior to admission.

MH (Initial) Someone on the staff explained to me what this document says in a language I understand.

Madison Hough
Patient's Signature Date

Witness 3/24/17
Witness Date

Relationship of Witness to Patient

Parent/Guardian Signature (if patient is minor) Date

_____ Sometime during the first 24 hours after I was admitted, someone on stal language I understand.

HOUGH, MADISON 018
M# 000010684 04/25/1998
A# 81072350010 03/25/2017
UNITED BEHAVIORAL HEALTH

Request for Release

As a voluntarily admitted patient at Mayhill Hospital, I am requesting to be released from this facility. I understand that 4 hours from the time this letter has been signed and dated, I must be released from my voluntary admission unless:

1. The request has been withdrawn by formally submitting a letter of retraction, or
2. After examination by a physician, an application for involuntary hospitalization is filed and an Order of Protective Custody has been initiated in accordance with Texas Mental Health Code.

I have been made aware of my rights as granted under the Texas Mental Health Code and am exercising my right at this time by making this request for release.

Signed: X Madison Hough	Time: 13:48	Date: 3-27-17
Room: 1-335	Physician: Faheem	
Witness (1):	Witness (2):	

Letter of Retractions, Request for Release

I, _____, after writing and submitting a letter requesting my release from voluntary admission to which I originally agreed, have decided to remain in Mayhill Hospital for further care and hereby request that my previous letter be disregarded.

Signed:	Time:	Date:
Room:	Physician:	
Witness (1):	Witness (2):	

Mayhill Hospital
BEHAVIORAL HEALTH

HOUGH, MADISON 018
M# 000010684 04/25/1998
A# 81072350010 03/25/2017
UNITED BEHAVIORAL HEALTH
DR. S. FAHEEM F IPL

Request for Discharge/AMA Questionnaire

Patient Name: Madison Haugh **Unit:** Adult or (Geri) **Date:** 3-27-17
Date of Admission: 3-25-17 Date of Request for Discharge: 3-27-17
Time of Admission: 2 am Time of Request for Discharge: 5-6 pm

1. What was your initial impression of the hospital?
   This was a place for people to heal themselves
2. Did you expect to participate in the Treatment Program?
   yes.
3. How long did you expect to stay in the hospital? 2-3 days
4. How did your expectations match with your experience in the hospital?
   They do match them, However the how long I was supposed to stay has not
5. What did you hope to gain from your treatment program?
   I hope to gain some support and an experience
6. How long did you expect it to take to resolve your issues and meet your therapy goals?
   2-3 days
7. What are your reasons for requesting discharge?
   I am ready to go. I feel great, I need to go back to school.
8. Please describe your level of satisfaction in the following areas:
   a. Physician: Great
   b. Nursing Staff: Great
   c. Therapy Staff: Great
   d. Intake: Great
9. Please indicate those staff members who offered assistance to you:
   Chad, Patrick, Ms Chastity and other nurses and techs
10. What do you think should have happened to assist you that has not occurred at this time?
    I think they should have truly listened to me
11. What recommendations do you have that will assist Mayhill Hospital in improving overall care of its patients?
    Truly listen, use Compassionate listening don't just asses the patients, listen to them with your heart, Not just your mind

Thank you for your response. (Do not maintain as part of medical records; forward to Performance Improvement Director)

Mayhill Hospital
BEHAVIORAL HEALTH

HOUGH, MADISON 018
M# 000010684 04/25/1998
A# 81072350010 03/25/2017
UNITED BEHAVIORAL HEALTH
DR. S. FAHEEM F IDI

ADHES MH-K03 Page 1

8-30-18

Sometimes I won't be doing anything at all and the Feelings hit me like a ton of bricks. Im trying to take it easy. I told Nawkowski about my new fear of Public restrooms She says exposure therapy might work. I mean, I did over come the fear of Psychologists and hospitals to come see her. So it might work. I tried using the bathroom in the hospital after our session at first I was uneasy, but when someone else walked in I freaked out and had to leave. Will work on that some more I suppose. I cry less when I mention the things that happened to her, but ~~it wasn't~~ despite that fact, my life has felt as if it was shattered. I can't escape that feeling either. I was so happy, everything was great, I was on

top of the world and all the sudden the grand under me was caved in and I fell. I fell hard and it feels like im buried alive and just barley digging my out. I still find it difficult to focus on things. I feel lost. Ive felt lost for over a year. I want to find myself but its like driving 150 mph thrugh fog at night and your headlights are out. Part of the Problem is im so confused all the same time! One thing at a time. I've tried making a strict schedule for myself. Sometimes, for a while now, getting out of bed is so hard! There are days I will lay in bed till 1pm or until I have to go to work. One day on my day off I didn't actually sleep, I was just in bed till 5pm. Who does that? I used to love

ADHES MH-K03 Page 3

mornings. But i'm finding it more unappealing. Mornings are beautiful. thats what I need a good morning. maybe I'll start forcing myself to get up. Plan a good breakfast and take Kai to the beach rather than the backyard. That would be good. Kai does help me get out more now. I need to think about him and his well-being. I guess thats more of a start towards that. lets hope I can do this atleast.

—Madisen Haygh

P.S. remember, you're not alone you have your family. Always.

ADHES
MH-K04
Page 1

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize Mayhill Hospital (healthcare provider) to use and disclose the protected health information described below to Mark Smith (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☑ 3/24/17 to 3/27/17.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☑ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): Any Video or Photographs

ADHES
MH-K04
Page 2

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until 1/1/18 (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Madison Haugh

Signature of patient or personal representative

Madison Haugh

Printed name of patient or personal representative and his or her relationship to patient

9/13/17

Date

ADHES
MH-K05

Madison Haugh

NO. 7
Name Madison Haugh
Date 10-15-19 DDC

EXHIBIT A.3

EVIDENCE RECEIVED AND EXAMINED

Yolanda McPherson

ADHES YM-Q1 Page 1

MILLWOOD HOSPITAL
Where We Believe in People

MCPHERSON, YOLANDA 5
000080210 12267510019 F
40
UNT4 A01/23/18 B04/21/63
S.MEHTA IPI

CONSENT FOR TREATMENT

Patient Name: _____

Advance Directives: I acknowledge information has been given to me on how to obtain an Advanced Directive. I understand it is my responsibility to provide the hospital with copies of any legal paperwork including but not limited to: Advance directives, Power of Attorney, and/or Guardianship.

		Available to Staff			Available to Staff
Mental Health Advance Directive	___ Yes ___ No	___ Yes ___ No	Medical Power of Attorney	___ Yes ___ No	___ Yes ___ No
Medical Advance Directive	___ Yes ___ No	___ Yes ___ No	Guardianship Papers	___ Yes ___ No	___ Yes ___ No
Are you an organ donor	___ Yes ___ No	___ Yes ___ No	Advanced directive needed	___ Yes ___ No	___ Yes ___ No

Consent for Treatment: I authorized Millwood Hospital, its staff and attending physicians to render to the patient all customary care, therapy, treatment, tests and procedures considered advisable, including emergency treatment and transportation to another facility if necessary. Further consent is also given for any diagnostic procedures, medical treatment, x-ray treatment, recreational activities and therapy, and other treatment ordered by Hospital and/or attending physicians including but not limited to services provided by other Healthcare Professionals to the patient.

I affirm I have retained no medications on my person and agree that all medications must be administered by a pharmacist or by a licensed nurse while a patient at the Hospital.

I understand the Hospital will not be responsible for the safety or care of the patient if the patient leaves the premises and will indemnify the Hospital for any loss or injury which may occur as a result of leaving against medical advice.

I understand that the use of reasonable restraint and/or confinement in accordance with, or as permitted by, applicable state law may be necessary, if severity of symptoms or behaviors warrants, in order to protect the patient from harming himself or others, or destroying property of the Hospital. Should such restraint and/or confinement become necessary during the patient's admission, I understand and agree to hold harmless the Hospital, its staff physicians, or other mental health professionals, from any claim resulting from any loss due to injury that may occur as a result of such restraint and/or confinement.

I authorize the staff to notify my family of any seclusion or restraining episode _____ Yes _____ No

_____ _____
Guardian/Significant Other Telephone

I acknowledge the information above regarding restraint and seclusions has been read and understood

_____ _____ _____ _____
Patient's Name Patient's Signature (or legal representative) Date Time

I acknowledge that the patient is under the control of an attending physician(s) and the Hospital is not liable for any act or omission in following the instructions of said physicians. The undersigned recognizes that certain healthcare professionals furnishing services to the patient, including, but not limited to, radiologists, pathologists, psychologists, physical therapists and/or licensed social workers may be independent contractors and may not be employees or agents of the Hospital. The undersigned further recognizes that the patient may be billed separately by their attending physicians and/or other healthcare professionals for their services provided.

Consents for admissions: I acknowledge that no guarantee or assurance has been made, as to the results of any services provided, including, but not limited to, therapy, treatment, tests or procedures, while admitted to the Hospital. I further understand that, unless otherwise disclosed the Hospital does not employ physicians and that the patients admitting physician and any other physician who may consult or provide services to the patient during this admission are not employed by and are not agents of the Hospital, but are independent physicians who exercise their judgement in the services they render.

I acknowledge that Millwood Hospital is a teaching facility and that professional students may have patient contact/access the patient's medical record information. These students are supervised by a licensed professional and are required to meet the hospital confidentiality standards.

I authorized the Hospital to search the personal belongings when it is reasonably believed that there may be or is in possession of an item or items which may be dangerous to his/her health or to the health of others. If any are found, it is understood that they will be maintained in a secure place and returned to the patient at discharge unless otherwise therapeutically contra-indicated by the attending physician.

I consent to the taking of photograph(s) for the purpose of identification _____ Yes _____ No
This photograph(s) may be permanently retained in the medical record.

I acknowledge that camera surveillance will be used while present on the psychiatric unit. I understand that this surveillance is used for the sole purpose of securing my safety while on the unit, review of patient observation rounds by Hospital staff members & incident reporting/investigations.

I release the Hospital from any liability for the loss or damage of personal property and money. Any property left behind at the time of discharge will be disposed of after 30 days. The hospital assumes no liability for loss or damage to vehicles parked on hospital premises. Patients are encouraged NOT to leave vehicles on premises.

Patient/Guardian Initials _____

ADHES YM-Q1 Page 2

Consent to acknowledge your presence: I acknowledge that no information will be given out regarding my presence here, unless Millwood Hospital has obtained a release of authorization to do so. I will be given a confidential Identification Number to be used for acknowledgement. I hereby give my permission to accept mail without the ID number. Furthermore, I consent to allow Millwood Hospital, to inform the patient's attending physician and/or referral sources of the admission to and progress at Millwood Hospital.

Responsibility for destruction of property: I understand that I am responsible for any damage to or destruction of Hospital property, or property belonging to others which may be located at the Hospital. I agree to accept liability for, and reimburse the Hospital or other owner of property, that I may damage or destroy.

Acknowledge receipt of patient advocacy policy: I acknowledge that a copy of the patient advocacy policy has been given to me. The policy has been explained, and I understand this policy.

Discharge policy information: I understand that it is the policy of the Hospital to attempt to provide a structured therapy regimen with effective quality treatment. If the treatment regimen is not completed prior to the exhausting of health insurance benefits; I agree to be liable for any charges incurred which are not paid by insurance in addition to the deductible and/or co-payment liability. I also understand that it is **NOT** Hospital policy to discharge or transfer patients or end treatment regimens simply because insurance benefits have been exhausted.

Release of Information: I authorized the Hospital to release any information or records contained in hospital patient records related to alcohol or substance abuse diagnosis or treatment, mental health treatment, or any communicable disease, including HIV/AIDS to (a) any of my treating practitioners, (b) my insurance company or health plan, (c) any other person or entity that is responsible for paying or processing for payment my hospital bill, (d) any other healthcare provider to which I am transferred for care, (e) entities using this information for quality management and peer review, and (f) any other person or entity as authorized by law. This release shall remain valid until I notify the Hospital, in writing, of my desire to revoke it.

Hospital Charges: Mental Health Inpatient: $1,625 IP per day includes room, board, nursing care, family, group, multifamily, activity, recreation and use of all facilities. This does not included bridge charges. Outpatient charges: $765 PHP per day, $545 IOP per day, OPS $142 per group.

Guarantee of payment: I guarantee the payment of the bill for services rendered by Millwood Hospital. I agree whether signing as guarantor or as patient, that in consideration of the services to be rendered to the patient, to be hereby jointly and individually obligated to pay the account(s) of the Hospital in accordance with the regular rates and terms of the Hospital. I understand I am responsible for all health insurance co-payment and deductibles. Should the account be referred for collection by an attorney or collection agency, the undersigned agree(s) to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any amount(s) not paid when due. I give permission to run a credit report on the guarantor or insured party if payment arrangements are requested on any accounts with Millwood Hospital.

Authorization for Receiving messages and automated calls: I give the Hospital (including its agents and third party collection agents) permission to contact me by telephone at the telephone number or numbers I provided during the registration process, or at any time in the future, including wireless telephone numbers or other numbers that may result in charges to me. The Hospital and its agents may leave messages for me at these numbers and may send text messages or email communications using the email address or address I provide. These voice messages and email and text communications may include information required by law (including debt collection laws) related to amounts I owe the Hospital as well as messages related to my continued care and treatment.

I also understand that the Hospital and its agents, including debt collection agencies, may use pre-recorded/artificial voice messages and/or use an automatic dialing device (an auto dialer) to deliver messages related to my account and amounts I may owe the Hospital. I also authorize the Hospital and its agents to use the number or numbers provided for such pre-recorded or auto dial messages. If I want to limit these communications to a specific telephone number or numbers, I understand that I must request that only a designated number or numbers may be used for these purposes.

Insufficient insurance coverage: I understand if my insurance or other third party coverage rejects the claim or pays only part of the claim, then I will be responsible for payment of the balance due, as determined by the Hospital or other Healthcare Professional.

Primary/Secondary insurance coverage: I understand it is my responsibility to furnish the Hospital with all of my insurance policies in order to authorize my care. I understand if I did not provide all insurance information at the time of admission, I will be responsible for any amounts not paid by either carrier, including but not limited to denied days due to no pre-authorizations.

Insured employer: I authorized Millwood Hospital to release and to obtain information from the Insured and/or Insured's Employer of the policy, regarding employment, verification of insurance coverage, benefits or any other information necessary to process the insurance claim.

Applicability to other providers: I agree that in the event other healthcare professional providers, including but not limited to other hospital(s), furnish services while in the Hospital, the consent(s), assignment(s), guarantee(s) and release(s) herein above set out shall apply to other such providers and services.

I acknowledge that the above information has been read and understood.

Patient's Name	Patient's Signature	Date	Admission Time
Yolanda McPherson	Yolanda McPherson	1/23/18	

Signature of Insured/Guarantor	Date	Signature of Legal Guardian	Date
Yolanda McPherson	1/23/18		

Signature of Insured/Co-Guarantor	Date	Signature of Hospital Staff	Date
			1/23/18

ADHES
YM-Q2
Page 1

MILLWOOD HOSPITAL
Center for Mental Health and Chemical Dependency Care
We Believe in People

MCPHERSON, YOLANDA 54
000080210 12267510019 F
40
UNT4 A01/23/18 B04/21/63
S.MEHTA IPL

MILLWOOD HOSPITAL/THE EXCEL CENTER
CONSENT TO RELEASE INFORMATION

Patient Name: S.MEHTA
Patient Number: _____

Should be signed at time of Admission

By signature below, I hereby authorize Millwood Hospital/The Excel Center to release and to obtain information with respect to any physical, psychiatric or drug/alcohol related condition, including treatment for Acquired Immune Deficiency Syndrome (AIDS) and/or HIV testing obtained during the course of diagnosis and/or treatment to/from the individual(s) or healthcare provider(s) below. The type of information authorized for disclosure includes, but may be limited to, that which is indicated below.

ACCESS	RELEASE TO/OBTAIN FROM	Purpose of Disclosure	Type of Information to be Disclosed	INITIAL each specific Consent to release
Referral	Primary Phone Address Secondary Address Phone	To identify persons supporting and using services. To aid in diagnosis continuing care and treatment	* Notification of admission and discharge, including Psychiatric Evaluation, reports of testing, discharge planning and summary. * Progress and treatment reports, Physical Exam Assessments	_____ Yes _____ No Initial: _____
Mental Health Professionals	Primary Phone Address Secondary Address Phone	To facilitate treatment involvement and communication To aid in diagnosis, continuing care and treatment	* Notification of admission and discharge, including Psychiatric Evaluation, reports of testing, discharge planning and summary. * Progress and treatment reports, including group therapy and other services * History and Physical, Assessments	_____ Yes _____ No Initial: _____
Primary Care Physician	Primary Phone Address Secondary Address Phone	To aid in diagnosis, continuing care and treatment	* Notification of admission and discharge, including Psychiatric Evaluation, reports of testing, discharge planning and summary. * Progress and treatment reports, including group therapy and other services * History and Physical, Assessments	_____ Yes _____ No Initial: _____
Physicians	Primary Phone Address Secondary Address Phone	To aid in diagnosis, continuing care and treatment	* Notification of admission and discharge, including Psychiatric Evaluation, reports of testing, discharge planning and summary. * Progress and treatment reports, including group therapy and other services * History and Physical, Assessments	_____ Yes _____ No Initial: _____
Law Enforcement Probation Attorney	Primary Phone Address Secondary Address Phone	To facilitate understanding and support in treatment To aid in diagnosis, continuing care and treatment	* Notification of admission diagnosis, discharge and plans for aftercare.	_____ Yes _____ No Initial: _____
E.A.P. Coordinator	Primary Phone Address Secondary Address Phone	To aid in diagnosis, continuing care and treatment	* Notification of admission and discharge, including Psychiatric Evaluation, reports of testing, discharge planning and summary. * Progress and treatment reports, including group therapy and other services, Assessments * History and Physical, Consultation reports	_____ Yes _____ No Initial: _____

MILLWOOD HOSPITAL/THE EXCEL CENTER
CONSENT TO RELEASE INFORMATION

PATIENT MCPHERSON, YOLANDA 54
000080210 12267510019 F
40
UNT4 A01/23/18 B04/21/63
S.MEHTA IPL

Forms/Admission packet - 03/14

ADHES YM-Q2 Page 2

ACCESS	RELEASE TO/OBTAIN FROM	Purpose of Disclosure	Type of Information to be Disclosed	INITIAL each specific Consent to release
Family Members or Significant Other	Name/Relationship Benjamin C. McPherson Phone 817 - 819-2033 Name/Relationship Husband Phone Austin C. McPherson Name/Relationship Son Phone Name/Relationship Montana McPherson Phone (Daughter)	To facilitate understanding and support in treatment To aid in continuing care and treatment	* Notification of admission, information on patient's treatment plans and discharge/aftercare plans. Physical Exam	✓ Yes ___ No Initial: mcp
School Teachers and Counselors	Name Address Phone Name Address Phone	To discuss and exchange written and verbal information to coordinate educational care	* Transcripts, Educational transcripts and other educational related information. * Psychological evaluations, Discharge and aftercare plans, Physical exam, Immunization	___ Yes ___ No Initial: ___
Employer	Name Supervisor Phone EAP Coordinator Phone Address	To facilitate understanding and support in treatment To aid in continuing care and treatment	* Notification of admission and discharge and plans for aftercare. Admitting diagnosis. * Treatment plans and progress reports *Information needed to obtain verification of insurance coverage and benefits.	___ Yes ___ No Initial: ___
Clergy	Name Address Phone Name Address Phone	To facilitate understanding and support in treatment To aid in continuing care and treatment	* Notification of admission diagnosis, discharge and plans for aftercare	___ Yes ___ No Initial: ___
Insurance	Name Aetna TRS Address Phone Name Address Phone	To aid in diagnosis, continuing care and treatment	* Notification of admission and discharge, including Psychiatric Evaluation, reports of testing, discharge planning and summary. *Progress and treatment reports, including group therapy and other services, Assessments *History and Physical, Consultation reports	✓ Yes ___ No Initial: mcp
	Name Address Phone Name Address Phone	To aid in diagnosis, continuing care and treatment	* Notification of admission and discharge, including Psychiatric Evaluation, reports of testing, discharge planning and summary. * Progress and treatment reports, including group therapy and other services, Assessments * History and Physical, Consultation reports	___ Yes ___ No Initial: ___

The above consents, initialed by me, are subject to revocation or change at any time except to the extent that Millwood/The Excel Center has acted in reliance thereon. If not previously revoked, the consents will terminate fourteen (14) days after the patient's discharge.

Notice to Recipients of Information: The information disclosed to you was taken from records of which the confidentiality is protected by Federal Law, Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

The confidentiality of alcohol and drug abuse patient records is protected by Federal Law and regulations. Generally, Millwood/The Excel Center may not disclose information to anyone outside of Millwood/The Excel Center which would IDENTIFY any patient as an alcohol or drug abuser unless the patient has consented in writing; the disclosure allowed by a court order, or the disclosure is made to medical or other qualified personnel in accordance with Federal regulations.

Patient's Signature: Montana McPherson Date: 1/23/18 Time: 4:15

Patient's Address: _____ Time: _____

Guardian or Parent Signature: _____ Date: _____ Time: _____

Witness Signature: [signature] Date: 1/23/18 Time: 1620

ADHES
YM-Q3

MILLWOOD HOSPITAL
Center for Mental Health and Chemical Dependency Care
We Believe in People

American Association of Suicidology
5521 Wisconsin Avenue, NW
Washington, DC 20015
Phone: (202) 237-2280
Fax: (202) 237-2280
Email: info@suicidology.org
Website: www.suicidology.org

Understanding and Helping the Suicidal Individual

BE AWARE OF THE WARNING SIGNS

Are you or someone you love at risk of suicide? Get the facts and take appropriate action.
Get help immediately by contacting a mental health professional or calling 1-800-273-8255 for a referral should you witness, hear, or see anyone exhibiting any one or more of the following:

- Someone threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself.
- Someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means.
- Someone talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person.
- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes
- No reason for living; no sense of purpose in life

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S.MEHTA

BE AWARE OF THE FACTS

1. Suicide is preventable. Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems.
2. Most suicidal individuals give definite warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them.
3. Talking about suicide does not cause someone to be suicidal.
4. Approximately 32,000 people commit suicide every year. The number of attempts is much greater and often results in serious injury.
5. Suicide is the third leading cause of death among people ages 15-24, and it is the eighth leading cause of death among all persons.
6. Youth (15-24) suicide rates increased more than 200% from the 1950's to the late 1970's. Following the late 1970's, the rates for youth suicide have remained stable.
7. The suicide rate is higher among the elderly (over 65) than any other age group.
8. Four times as many men kill themselves as compared to women, yet three times as many women attempt suicide as compared to men.
9. Suicide occurs across all age, economic, social, and ethnic boundaries.
10. Firearms are currently the most utilized method of suicide by essentially all groups (male, female, young, old, white, non-white).
11. Surviving family members not only suffer the trauma of losing a loved one to suicide, and may themselves be at higher risk for suicide and emotional problems.

WAYS TO BE HELPFUL TO SOMEONE WHO IS THREATENING SUICIDE

1. Be aware. Learn the warning signs.
2. Get involved. Become available. Show interest and support.
3. Ask if he/she is thinking about suicide.
4. Be direct. Talk openly and freely about suicide.
5. Be willing to listen. Allow for expression of feelings. Accept the feelings.
6. Be non-judgmental. Don't debate whether suicide is right or wrong, or feelings are good or bad. Don't lecture on the value of life.
7. Don't dare him/her to do it.
8. Don't give advice by making decisions for someone else to tell them to behave differently.
9. Don't ask 'why'. This encourages defensiveness.
10. Offer empathy, not sympathy.
11. Don't act shocked. This creates distance.
12. Don't be sworn to secrecy. Seek support.
13. Offer hope that alternatives are available, do not offer glib reassurance; it only proves you don't understand.
14. Take action! Remove means! Get help from individuals or agencies specializing in crisis intervention and suicide prevention

Patient Signature: [signature] *Date/Time:* 1/31/18 12:30p
Family/Support Person Signature: _____ *Date/Time:* _____
Staff Signature: [signature] *Date/Time:* 1/31/18 12:30p

ADHES YM-Q4

My Safety Crisis Plan

Recognize your warning signs and use your coping skills to keep yourself safe and healthy.

Triggers and Stressors

(Behaviors, situations and circumstances that put you at emotional risk)

Husband being a Sr. pastor stressful
overwhelming concern for children
Doesn't have time for "myself"

Things to do... My goals for healthy behavior:

1. Find a happy medium w/ husband
2. Find some "me" time
3. Take a bubble bath
4.
5.

Warning Signs

(Your behavior signals that show you're growing more and more at risk)

→ shut down
→ decreased sleep
→ decreased appetite
→
→
→
→ Call someone and ask for help.

People to contact...

- 911 (817) 241 3121
- (NAME of FACILITY CONTACT/Phone # for emergencies related to this stay: Millwood

Physician Name: Attia

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
1-800-273-TALK(8255)

[illegible] does not have access to:
(Patient/Resident)

- Prescription medications for use other than as prescribed
- Weapons
- Lethal medications
- Other means of self-harm

This has been verified by: Via FT: 1-26-18
(Parent/Guardian or Support Person)
husband

My Coping Skills...
What I can do to be calm and stay safe IN THE MOMENT:

"I want some alone time"

What can my support person do to help me? "Give me some time alone"

Reminders

- ➢ Take medications as ordered – do not change the dose or time unless directed by your physician.
- ➢ If you experience side effects from your medications – notify your outpatient provider or PCP
- ➢ For Children/Adolescents – Medication should be kept out of reach and in a secure place
- ➢ Keep all aftercare appointments as scheduled – take your copy of aftercare plan to your appointment

Patient: [signature] Date: 1/24/18 ☑ Received Copy 12:30p
Support Person: Date: ☐ Received Copy
Staff: [signature] Date: 1/24/18
[signature] 1/24/18

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ADHES YM-Q5

FT. 1-2to-18

AFTERCARE PLAN/INSTRUCTIONS *(Take this form with you to appointment.)*

Discharge Date: 01/31/18	**Reason for Discharge:** ☒ Routine ☐ At Patient Request ☐ AMA ☐ MOT ☐ Other, explain

SOCIAL SERVICES TO COMPLETE

Living Arrangement: ☑ Own Home ☐ Family ☐ Group Home ☐ Shelter ☐ Nursing Facility ☐ Other:

Mode of Transportation: Husband **Resources for Meds/co-pay?** ☑Yes ☐No **Patient/Guardian Responsible for Meds?** ☑Yes ☐No

Principal Diagnosis: Major Depressive Disorder, single severe without psychosis; Anxiety disorder not otherwise specified

Reason for Hospitalization: mood stabilization

REFERRALS /FOLLOW-UP *(Call to confirm within 24 hours of discharge)*

Individual/Family Therapy
Treatment Plan and Medication List, Safety Plan, Advanced Directives forwarded to next level of care provider? ☐ Yes ☑ No Reason: no fax provided
Date: _____ Time: _____

Name of Provider: Destination Life Therapy and Wellness Mrs Zenaida Cooke
Phone: 817.809.2249 Fax: No fax provided
Address: 1759 Broad Park Circle, Suite 113, Mansfield, TX 76063
Appointment: Date: _____ Time: _____ PT to call and schedule appt.

Medication Management (Physician)
Treatment Plan and Medication List, Safety Plan, Advanced Directives forwarded to next level of care provider? ☒ Yes ☐ No Reason: _____
Date: 2-1-18 Time: 1:55pm

Name of Provider: Dr. Seema Haque
Phone: 817.719.3770 Fax: 1-866-262-1819
Address: 1831 E. Broad St., suite 211, Mansfield TX 76063
Appointment: Date: 02.14.18 Time: 2:00pm 10-15 mins early

School (Education Support Services)
'Return to School Plan' available for campus listed

School Name: _____ **Phone:** _____

RESOURCES

Resource Information	SUICIDE CRISIS:	Referral to Outpatient Tobacco Use Treatment/Counseling
Dial 211	Millwood Hospital: 817.261.3121	☐ Patient Referred, appointment: _____
Prescription Assistance Program	Suicide Hotline: 1.800.448.4600	☐ Patient Refused ☑ N/A
1-800-444-4106	Suicide Prevention Education Provided? ☑ Yes ☐ No	**Texas Tobacco Quitline:** 1-877-937-7848
		http://www.dshs.state.tx.us/tobacco/quityes.shtm

NA: 817-624-9525	MHMR Mobile Crisis Unit	Youth Crisis Hotline	ALCOHOL/DRUG USE TREATMENT
AA: 817-332-3533	1.800.866.2465	1.800.448.4663	☑ N/A ☐ PT REFUSED ☐ REFERRAL MADE: _____

PATIENT CHOICE LETTER Your physician has recommended continued services as you leave the facility. You have the right to select who and where these services are provided. The case management staff has assisted you in locating service providers listed above and in some cases have made appointments for you. To the best of our knowledge, the above named providers are included in your insurance panel although these panels change frequently. *It is ultimately your responsibility to confirm this information and your appointment with the providers.* **I understand the above discharge instructions and choose to accept the referrals made. If I have any questions, I understand I may call Millwood Hospital at 817.261.3121 and request the "Nurse Supervisor" for 24-hour/7-day week emergency access to medical records, obtaining information concerning the inpatient stay and/or obtaining results of studies pending at discharge. I am aware of the advocacy system available to me should I have any concerns about my treatment or discharge plans. My signature will document my consent for release of this document, crisis safety plan, emergency advanced directives and the medication reconciliation to the above listed providers.**

PATIENT/FAMILY UNDERSTANDING OF AFTERCARE PLAN

☑ Patient/Family able to verbalize discharge instructions ☑ Patient/family verbalizes understanding of when/how to seek treatment ☐ Educational materials provided to patient re: _____

Patient Signature: Yolanda McPherson
Patient Phone Number: 817.819.2633
Address: 212 Bankston Lane, Mansfield TX 76063
Parent/Guardian Signature: _____
Patient/Guardian Phone Number: _____

D. Cannon, LMSW 01.31.18 12:18p
Therapist/Discharge Planner Signature, Date/Time

Nurse RN 1/31/18 12:30p
Discharge Nurse Signature, Date/Time

MILLWOOD HOSPITAL

AFTERCARE PLAN/DISCHARGE INSTRUCTIONS (Revised 7.1.17)

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ADHES
YM-Q6

MILLWOOD HOSPITAL CONTINUING CARE DISCHARGE PLAN ORDER FORM AND PATIENT INSTRUCTIONS FOR HOME MEDICINES

Take These Medicines at Home:	Dose	Route	Frequency	Medication Supply *Key Below	You are Taking This Medicine For:
Zoloft	50mg	By Mouth	In the Morning	(Rx) Home OTC	mood #30
Triamterene HCTZ	37.5mg 12.5mg	By Mouth	In the Morning	(Rx) Home OTC	HTN #30
protonix	40mg	By Mouth	In The Morning	(Rx) Home OTC	GERD #30
				Rx Home OTC	
				Rx Home OTC	
				Rx Home OTC	
				Rx Home OTC	
				Rx Home OTC	
				Rx Home OTC	
				Rx Home OTC	

❑ Tobacco Cessation Prescription: ____________

❑ Patient Does not want Tobacco Cessation medication ❑ N/A (patient does not use tobacco)

STOP **Stop Taking These Medicines at Home:** STOP

1.	4.
2.	5.
3.	6.

Primary Care Physician:
Critical Labs Faxed: ❑ Yes ❑ No ☒ N/A
If yes, forwarded to next level of care provider?
❑ Yes ❑ No If No, reason: ____________
Mode: ❑ Fax ❑ Mail ❑ Electronic ❑ Other
Date: N/A Time: N/A

Medical Follow-Up Required: ❑ No ❑ Yes If yes complete section below
Name of Provider: ____________
Phone: ____________ Fax: ____________

Medical Appointment: Date: ____________ Time: ____________
Follow up for: —

Procedures/Tests Performed During Hospitalization: ☒ Lab ❑ X-ray ❑ EKG ❑ Other, ____________

Special Instructions: 1. Diet Restrictions ☒ No ❑ Yes ____________ 2. Potential Drug/Food Interactions ☒ No ❑ Yes
(Discharge Medication Reconciliation Form attached) 3. Activity Restrictions ☒ No ❑ Yes ____________ 4. Other: ____________

Yolanda McPherson — Patient/Guardian Printed Name
[signature] — Signature
1/31/18 — Date / 12:30p — Time

Nneoma. O — RN Staff Printed Name
[signature] — Signature
1/31/18 — Date / 12:30p — Time

Physician Printed Name ____________
[signature] 1/31/18 1300 — Signature
Date ____________ / Time ____________

*Key—
Rx: Prescription provided
Home: Medications available at home
OTC: Medication is available over the counter

MCPHERSON, YOLANDA 54
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UNT4 A01/23/18 B04/21/63
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Dated this 21st day of August, 2019.

On Behalf of: _____

_____

THIEBAUD REMINGTON THORNTON BAILEY, LLP
4849 Greenville Avenue, Suite 1150
Dallas, Texas 75206
214-954-2200

ADHES
YM-K02

HIPAA-COMPLIANT AUTHORIZATION TO DISCLOSE PATIENT-IDENTIFIABLE HEALTH INFORMATION

TO: RE: **Yolanda McPherson**

1.00 **NATURE OF AUTHORIZATION:** I hereby authorize the use or disclosure of my patient-identifiable health information as described below. This authorization is in accordance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations and applicable state privacy laws and regulations.

2.00 **ENTITY(IES) AUTHORIZED TO MAKE DISCLOSURE:** The following individual or organization is authorized to make the disclosure:

_____

3.00 **ENTITY TO WHICH DISCLOSURE IS AUTHORIZED AND INFORMATION TO BE DISCLOSED**: Upon presentation of this authorization, or a photostatic copy thereof, the individual or organization named above is authorized and requested to furnish to **THIEBAUD REMINGTON THORNTON BAILEY, LLP,** or to any persons designated by them in writing, the following type and amounts of patient-identifiable information in electronic format if available.:

Any and all items requested relating to the treatment or care provided by you, your agents and employees, to the above named patient, and/or the undersigned, including all records; reports; correspondence; notes; consultations; imaging films, (including x-rays, sonograms, CT and MRI scans); monitor strips; billing statements, or other information pertaining to the treatment provided to the patient, and/or the undersigned, for any and all injuries, illnesses and/or conditions, including drug/alcohol/mental health/communicable disease and/or AIDS testing and treatment.

I understand that the information in the health records you furnish may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

4:00 **PURPOSE OF DISCLOSURE:** For potential use as evidence in legal proceedings.

5.00 **EXPIRATION OF AUTHORIZATION:** I understand I have the right to revoke this authorization at any time before it expires. I understand that if I revoke this authorization I must do so in writing and present my written revocation to you, and that any such revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one hundred and eighty (180) days from the date of my signature below.

6.00 **UNDERSTANDING OF RIGHTS AND POTENTIAL FOR REDISCLOSURE:** I understand that authorizing the disclosure of this health information is voluntary, and I that have the right to refuse to sign this authorization. I also understand that I may inspect or copy the information to be used or disclosed, as provided by 45 CFR 164.524. I understand that if the recipient authorized to received this information is not a covered entity (e.g., insurance company or health care provider) the released information may no longer be protected by federal and state privacy regulations. I understand that any disclosure of this information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that the signing of this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

Dated this 21st day of August, 2019.

Yolanda McPherson

Patient or Other Legally Responsible Person

Relationship to Patient (If other than Patient) and Description of Authority

456-13-0761
Patient's Social Security Number

04/21/1963
Patient's Date of Birth

ADHES
YM-K03

CareFlite
Patient Care Record

Name: MCPHERSON, YOLANDA **Incident #:** 18-008172 **Date:** 01/23/2018 Patient 1 of 1

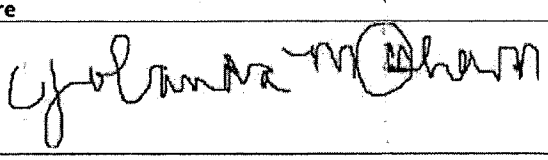
Billing Authorization

Authorization	HIPPA Consent for Treat/Transport

Section I - Patient / Parent of Minor Authorization Signature

Patient Consent to Treatment, Privacy Acknowledgement & Billing Authorization I request that payment of authorized Medicare, Medicaid, or any insurance benefits be made on my behalf to CareFlite for any services provided to me by CareFlite now, in the past or in the future. I understand that I am financially responsible for the services provided to me by CareFlite, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to CareFlite any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to CareFlite. I authorize CareFlite to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to CareFlite and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by CareFlite, now or in the future. A copy of this form is as valid as an original. I consent to transportation and treatment by and have received a copy of CareFlite's Notice of Privacy Practices. If patient is unable to sign for themselves, the Authorized Signer, signing on behalf of the patient, recognizes that signing on behalf of the patient is not acceptance of financial responsibility for the services rendered.

Signature



Signed On	01/23/2018 12:54:40
Notice of Privacy Practices Provided	
Printed Parent Name	
Billing Authorization	Agree
HIPAA Acknowledgement	Agree

Section II - Authorized Representative Signature

Complete this section only if the patient is physically or mentally unable to sign.
Authorized representatives include only the following:(Check one)

Patient's Legal Guardian
Patient's Medical Power of Attorney
Relative or other person who receives benefits on behalf of the patient
Relative or other person who arranges treatment or handles the patient's affairs
Representative of an agency or institution that provided care, services or assistance to patient

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payer for any services provided to the patient by the transporting ambulance service now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Signature

Signed On	
Notice of Privacy Practices Provided	
Printed Name	
Reason unable to sign	

01/29/2018 22:41:42
PCRID: 5f9c3d81-34c8-45bf-aef8-a87100c2078a
Electronically Signed by: Baker, Collin
Template Version: PCR-WEB-1.1.8
Data Version: 00000-00000000022077F0

ADHES
YM-K04

Form **4506**
(September 2018)
Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
Yolanda E. McPherson	
2a If a joint return, enter spouse's name shown on tax return.	**2b** Second social security number or individual taxpayer identification number if joint tax return
Benjamin C. McPherson II	

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

Yolanda E. McPherson 1212 Bakston Ln. Mansfield TX 76063

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax return to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your return information, you can specify this limitation in your written agreement with the third party.

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

8	**Fee.** There is a $50 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ Signature (see instructions) — Date: 02-12-2019

▶ Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ Spouse's signature — Date: 02-12-2019

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 41721E Form **4506** (Rev. 9-2018)

EXHIBIT A.4

EVIDENCE RECEIVED AND EXAMINED

Tiffany Young

ADHES TY-Q1

HICKORY TRAIL HOSPITAL
PATIENT RIGHTS: CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

You have the **right to decide** whether **to take psychoactive medicine** as recommended by your doctor. **Psychoactive medications include antidepressants, antipsychotics, anxiolytics/sedatives/hypnotics, MAO inhibitors, mood stabilizers, stimulants.** You can agree to take the medicine; this agreement is called "consent". You have the right **not** to agree to take psychoactive medicine. If you do not agree to take, or if you object to taking the psychoactive medication medicine, your objection will be recorded in your medical file. You have the right to withdraw your consent to treatment with psychoactive medications at any time.

There may be a person who is authorized to **agree or object for you.** That person is called your **"legally authorized representative".** Your "legally authorized representative" would be a person appointed legally or by a court to look after your well-being, usually called a guardian; or your parent or guardian if you are a minor. No other person can consent or object for you.

You have the right to know what may happen if you do not choose to take psychoactive medicine. You should be told whether not taking the medicine may cause the occurrence, increase or reoccurrence of mental illness.

You have the right to be informed about and to discuss with your doctor any other types of treatment your doctor thinks can reduce or control your symptoms and help you feel better. You are entitled to know this before you give your consent or before you make an objection to taking the medicine. You have the right to know how the medicine will be given to you, how frequently and for how long it will be given to you.

ave the right to know that all medicines have side effects, some are mild and some severe. Some side effects may be permanent. You have the right to know this before giving your consent or making your objection to taking the medicine.

You have the right to know what side effects might occur if you take the medicine. You have the right to know which side effects that you, as an individual, may likely experience. You have the right to know what kind of permanent problems may occur because of taking the medicine for a long time or in a large amount. Written material which describes the risks and benefits of the medicine will be given to you, and if necessary read to you or your legally authorized representative before any psychoactive medication is administered to you.

You need to immediately tell your doctor or the staff at the hospital if you have any problems while taking the medicine. You should always te ur doctor or the staff about any medicines you are allergic to.

nese things have been explained to you, you still have the right to object to the medication. However, you may be given appropriate medication without your consent if there is a situation in which it is immediately necessary to give medication to you to prevent:

1. Imminent or probable death or substantial bodily harm to yourself if you;
   - A. openly or continually threaten or attempt to commit suicide or seriously bodily harm, **or**
   - B. are behaving in a manner that indicates that you are unable to satisfy your need for nourishment, essential medical care, or self-protection, **or** there is
2. Imminent physical or emotional harm to others because of your threats, attempts, or other acts which are openly ntinually made or done.

I have received the Consent to Treatment with Psychoactive Medication Information Sheet (MHRS 9-7.1) and I understand that I will receive printed material which summarizes specific information regarding any psychoactive medication(s) which my physician may prescribe.

Based upon this information, I will be asked to consent to treatment with a specific psychoactive medication or medication group (class). I understand that after I consent, I may withdraw the consent at any time, however a probate court may decide that I lack the capacity to make the decisions whether or not to take the medication(s) and decide that I must continue taking the psychoactive medication prescribed by my physician.

Tiffany Young — Patient — Date 11/5/17 — Time 14:35

Legally Authorized Representative — Role — Date — Time

Witness — Date 11/5/17 — Time 14:35

ted from MHRS 9-7.1

YOUNG, TIFFANY
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A# 10236060017 I IPL 1
11/05/2017 14:11
R.SHIWACH MD

ADHES
TY-K01

PET THERAPY PROGRAM CONSENT FORM
Patient Agreement to Participate

PLEASE READ THIS CAREFULLY. YOU WILL BE ASKED TO SIGN IT.

Benefits: I am voluntarily choosing to participate in a Pet Therapy Program being sponsored by Hickory Trail Hospital ("Facility").

I understand that this type of program has been instituted in other patient care settings and that studies how shown that pets can have a beneficial effect on health and well- being providing companionship, love, increased physical activity and emotional responsiveness.

Risks: I am aware and have been informed of the fact that live, domestic animals will be provided by volunteers to be used in the Pet Therapy Program. I understand that the behavior and reactions of the animals are not entirely predictable, and therefore, the animal providers cannot guarantee that the animal will behave properly or that the animal will not bite, claw, scratch or otherwise inflict injury. I also am aware of no allergy, skin or respiratory sensitivity or other medical condition that I have which might make touching, handling or being in close proximity to dogs, cats and other domestic animals used in the program, potentially harmful to my health.

Agreement: I have been assured that the volunteers providing the animals have carefully selected them and that the animals to be used have never shown any vicious tendencies heretofore. I have been assured that the activities in the Pet Therapy Program will be supervised at all times by staff and volunteers of Facility. I agree to handle the animals gently. I will try to avoid provoking an angry response from the animal. I understand that I would be provided, within the capability of Facility, medical assistance for any physical injury that may result from my participation in this program. I agree to assume the risk of any injury or illness resulting from my participation and agree to hold Facility and the staff harmless for the actions of the animals used in this program.

Photographs: I understand the taking of a photograph is optional and will be used only for the purpose described, and will not be otherwise released without my express permission. The photograph will not be retained in the patient's medical records.

Patient Signature Date: 11/5/17 Time: 14:35

Substitute Decision Maker Signature Date: _____ Time: _____
(If patient/minor is unable to sign)

Staff Member Signature Date: 11/5/17 Time: 14:35

123634v1
(Revised 7/7/2016)

YOUNG, TIFFANY
000048041 02/07/1972 045
A# 10236060017 I IPL 1
11/05/2017 14:11
R.SHIWACH MD

ADHES TY-K02

YOUNG, TIFFANY
000048041 02/07/1972 045
A# 10236060017 I IPL 1
11/05/2017 14:11
R.SHIWACH MD

HICKORY TRAIL HOSPITAL
BEHAVIORAL HEALTH SERVICES

FINANCIAL AGREEMENT

The undersigned hereby agree as follows:
Patient Name: Tiffany Young

GUARANTEE OF PAYMENT
The undersigned hereby agree(s) to guarantee the payment of the bill for services rendered by Hickory Trail Hospital. The undersigned agree(s) whether signing as guarantor or as patient, that in consideration of the services to be rendered to the patient to be hereby jointly and individually obligated to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred for collection to an attorney or collection agency, the undersigned agree(s) to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any amount(s) not paid when due.

ASSIGNMENT OF INSURANCE BENEFITS
In consideration of hospital and medical services rendered or to be rendered by Hickory Trail Hospital, to the extent permitted by law. I herby (1) irrevocably assign, transfer and set over to Hickory Trail Hospital (2) all of my rights, title and interest to medical reimbursement, including, but not limited to, (3) the right to designate a beneficiary, add dependent eligibility and (4) to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by Hickory Trail Hospital during the pendency of the claim for this admission. Such irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of Hickory Trail Hospital to pursue any such right of recover)'. I herby authorize the insurance company(ies) or third party payor(s) to pay directly to Hickory Trail Hospital all benefits due for services rendered.

APPLICABILITY TO OTHER PROVIDERS
The undersigned agree(s) that in the event other healthcare professional providers, including but not limited to other hospital(s), furnish services to the patient while in Hickory Trail Hospital, the consent(s). assignment(s), guarantee(s) and release(s) herein above set out shall apply to other such providers and services.

INSUFFICIENT INSURANCE COVERAGE
If any insurance or other third part)' coverage which the patient may have rejects the patient's claim or pays only part of the claim the undersigned shall be responsible for payment of the balance due, as determined by the Hospital or other Healthcare Professional.

INSURED EMPLOYER
By signature below, I hereby authorize Hickory Trail Hospital to release and to obtain information from the Insured and Insured's Employer of the policy regarding verification of insurance coverage, benefits or any other information necessary to process the patient's insurance claim.

The undersigned acknowledges that this agreement has been read and is understood and authorizes Hickory Trail Hospital to review and/or inquire into my credit history using any means available to obtain a current Credit Bureau History Report.
The undersigned further acknowledges and understands that the physician's charges will be billed separately from or in addition to charges that may be billed by the Hospital or other Healthcare Professionals who may provide services to the patient.

Tiffany Young		11/5/17	14:35
Patient's Name (Print)	Patient's Signature	Date	Time
Signature of Insured/Guarantor	Date	Signature of Legal Guardian—Next of Kin	Date Time
Insured Employer	Phone Number	Signature of Hospital Staff	11/5/17 14:35 Date Time

ADHES
TY-K03

Form **4506**
(September 2018)
Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ Do not sign this form unless all applicable lines have been completed.
▶ Request may be rejected if the form is incomplete or illegible.
▶ For more information about Form 4506, visit www.irs.gov/form4506.

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first. James Clint Young Tiffany Young	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)
Young / Meera Ct. Mansfield, TX 76063

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax return to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your return information, you can specify this limitation in your written agreement with the third party.

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

8	**Fee.** There is a $50 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ Signature (see instructions) — Date 12/21/19

▶ Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ Spouse's signature — Date 12/21/19

ADHESTY-K04

HIPAA-COMPLIANT AUTHORIZATION TO DISCLOSE PATIENT-IDENTIFIABLE HEALTH INFORMATION

TO: RE: **Tiffany Young**

1.00 **NATURE OF AUTHORIZATION:** I hereby authorize the use or disclosure of my patient-identifiable health information as described below. This authorization is in accordance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations and applicable state privacy laws and regulations.

2.00 **ENTITY(IES) AUTHORIZED TO MAKE DISCLOSURE:** The following individual or organization is authorized to make the disclosure:

3.00 **ENTITY TO WHICH DISCLOSURE IS AUTHORIZED AND INFORMATION TO BE DISCLOSED:** Upon presentation of this authorization, or a photostatic copy thereof, the individual or organization named above is authorized and requested to furnish to the **LAW OFFICES OF SCHELL COOLEY RYAN CAMPBELL, LLP,** or to any persons designated by them in writing, the following type and amounts of patient-identifiable information in electronic format if available.:

Any and all items requested relating to the treatment or care provided by you, your agents and employees, to the above named patient, and/or the undersigned, including all records; reports; correspondence; notes; consultations; imaging films, (including x-rays, sonograms, CT and MRI scans); monitor strips; billing statements, or other information pertaining to the treatment provided to the patient, and/or the undersigned, for any and all injuries, illnesses and/or conditions, including drug/alcohol/mental health/communicable disease and/or AIDS testing and treatment.

I understand that the information in the health records you furnish may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

4:00 **PURPOSE OF DISCLOSURE:** For potential use as evidence in legal proceedings.

5.00 **EXPIRATION OF AUTHORIZATION:** I understand I have the right to revoke this authorization at any time before it expires. I understand that if I revoke this authorization I must do so in writing and present my written revocation to you, and that any such revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one hundred and eighty (180) days from the date of my signature below.

6.00 **UNDERSTANDING OF RIGHTS AND POTENTIAL FOR REDISCLOSURE:** I understand that authorizing the disclosure of this health information is voluntary, and I that have the right to refuse to sign this authorization. I also understand that I may inspect or copy the information to be used or disclosed, as provided by 45 CFR 164.524. I understand that if the recipient authorized to received this information is not a covered entity (e.g., insurance company or health care provider) the released information may no longer be protected by federal and state privacy regulations. I understand that any disclosure of this information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that the signing of this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

Dated this 15th day of February 2019.

Patient or Other Legally Responsible Person

Relationship to Patient (If other than Patient) and Description of Authority

466-97-9028
Patient's Social Security Number

02/07/1972
Patient's Date of Birth

ADHES
TY-K05

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

TO:

RE: **Tiffany Young**
DOB: **02/07/1972**
SSN: **466-97-9028**

Upon presentation of this authorization, or a photostatic copy thereof, you are authorized to furnish to the **Law Offices of Schell Cooley Ryan Campbell, LLP, Addison, Texas** or to any persons designated by them, any and all information that they may request, including, but not limited to all employment records in your files regarding the above named individual and/or the undersigned. Please honor this authorization or any photostatic copy thereof. Your cooperation with the above firm of attorneys and their representatives will be appreciated.

Dated this 21st day of February, 2019

On Behalf of: _____

_____

SCHELL COOLEY RYAN
CAMPBELL, LLP
5057 Keller Springs Road, Suite 425
Addison, Texas 75001
214-665-2000

ADHES TY-K06

Ketamine of North Texas, LLC

4100 Fairway Drive, Suite 200
Carrollton, Texas 75010
972-221-1741 Fax 972-428-2043

Please read & initial the following statements concerning our office policies:

TM I certify that the information I have given of this form is true and correct to the best of my knowledge.

TM I understand that payment is required at the time services are rendered and assume responsibility for this. I understand that there is a $30.00 fee for all returned checks.
(Note to divorced parents: Payment is the responsibility of the parent who brings the child into the office for treatment, regardless of the terms outlined in the divorce decree. The divorce decree is a matter between the divorced parents and the courts and we cannot be placed in the middle.)

TM I understand that insurance will only be filed with insurance companies that Dr. Nishendu Vasavada is contracted with. In order to achieve this, I must have all current insurance information on file. I understand that secondary insurance is not filed.

TM I understand that if there are any changes in my insurance coverage, I will notify the business office **5 days prior** to my next appointment or the visit will be self-pay or rescheduled.

TM I understand that all information obtained in regards to my insurance coverage is not a guarantee of payment by my insurance company. The amount collected at the time of service is only an estimate. I understand that I am ultimately responsible for any and all balances on my account.

TM I understand that it is my responsibility to keep my appointments. If I am unable to keep my appointments, I will notify the office at least 24 hours in advance.

TM I understand that I will be charged $50 for the time reserved if I do not call and cancel or reschedule at least 24 hours prior to my scheduled appointment.

TM I understand that regular office hours are Monday - Friday, 8:30 a.m. to 5:00 p.m.

TM I understand that it is my responsibility to keep track of my medication supply. I understand that I should request refills during regular office hours and that requests received will not be called into the pharmacist until the next business day.

TM I understand that my records are protected by special laws governing psychiatric/substance abuse records and that I must sign a Release of Information before any records can be released.

I hereby authorize Ketamine of North Texas to provide infusion services to (*please check one*)

☑ myself (or) ☐ my child

[signature] 1/15/19

Signature of Patient or Parent *(if patient is a minor)* **Date**

****

NOTICE CONCERNING COMPLAINTS:

Complaints may be reported to: Texas State Board of Medical Examiners
ATTN. Investigations
1812 Centre Creek Dr., Suite 300
P.O. Box 149134
Austin, Texas 78714-9134
Phone Number 800.201.9353

ADHES TY-K07 Page 1

KETAMINE CLINIC OF NORTH TEXAS, LLC

PATIENT'S RIGHTS AND RESPONSIBILITIES

This Clinic presents a Patient's Bill of Rights and Patient Responsibilities with the expectation that they will contribute to more efficient patient care and greater satisfaction for the patient, family, physician and center organization.

Patients shall have the following Rights and Responsibilities without regard to age, race, sex religion, culture, physical handicap and personal values or beliefs.

PATIENT' RIGHTS

You, the patient, have the right to accept or refuse medical care or treatment to the extent of the law. You will be informed of the medical consequences of such refusal. You are responsible for your actions should you refuse treatment or fail to follow your physician or Clinic's instructions. You will be requested to sign a release of responsibility form. If you refuse to sign a release of responsibility form, a registered letter will be sent to your current address on file.

You have the right to approve or refuse the release of your medical records to an individual outside the surgery center the exceptions being in case of a transfer to another medical facility or as required by law.

You have the right to be informed of any human experimentation or other research/education projects affection your care or treatment. You have the right to refuse participation in such experimentation or research without compromising the patient's usual care.

You have the right to be fully informed before transfer to another facility or organization.

The care rendered reflects consideration of you as an individual with personal values and a belief system. You are allowed to express your spiritual beliefs and cultural practices that do not harm others or interfere with your planned care/medical intervention.

Your designated representative has the right to participate in the consideration of ethical issues that arise during your care.

Your will be treated with consideration, respect and full recognition of individuality, including privacy in treatment and care. The Clinic will keep records and all personal matters that relate to you confidential.

You will be provided with complete information, to the extent of the physician's knowledge, regarding diagnosis, treatment, and prognosis as well as alternative treatments or procedures and the possible risk and side effects associated with the treatment or procedure.

You or a designated representative will be fully informed of the services and provisions for after-hours and emergency care available at the Clinic.

You have the right to information regarding fees, payment policies and may request an explanation of your bill regardless of the source of payment.

You have the right to inquire about the professional status of individuals providing your care.

You will receive the care needed to help you regain or maintain your maximum state of health.

You have the right to know what facility rules and regulations apply to your conduct as a patient.

You have the right to present and **Advance Directive**, such as a living will or healthcare proxy. A copy of any Advance Directive may be provided to the Clinic and physician. **However, it is our policy for the staff to provide all life saving methods to any patient in an emergency situation.**

ADHES
TY-K07
Page 2

KETAMINE CLINIC OF NORTH TEXAS, LLC

You have the responsibility to observe the rules and regulations of the Clinic for your stay and treatment. If the instructions given by the Clinic staff are not followed, you may forfeit the right for care at the Clinic and you will be responsible for your won outcomes.

You are responsible for promptly fulfilling your financial obligation to the Clinic.

You have the responsibility to be considerate of other patients, families and personnel by assisting in the control of noise, smoking and other distractions. You and your family are expected to respect the property of others.

You are responsible for reporting to the staff whether or not you understand the planned course of your treatment and what is expected of you.

You have the responsibility to ask your doctor or nurse any questions you have concerning pain management or pain relief options and to assist you doctor or nurse in assessing your pain. You are expected to tell you doctor or nurse about any worries you have about taking pain medications.

You are responsible for notifying the Clinic or your physician if you can not keep your appointment.

You and your family are responsible for providing the caregivers with accurate and complete information regarding present conditions, past illnesses, hospitalizations, medications or any other pertinent medical history.

It is your responsibility to fully participate in decisions involving your care and to accept the consequences of these decisions.

You are expected to follow up on your doctor's instructions, take medications when prescribed and ask questions concerning your health care that you feel are necessary.

GRIEVANCE POLICY STATEMENT

The Clinic provides for and welcomes the expression of grievances/complaints and suggestions by the patient and patient's family at all times. This feedback allows the Clinic to understand and improve the patient's care and environment.

The grievance process begins with the facility administrator. If the patient is still not satisfied, the process is given to the facility owner. In the event the problem is still not resolved; the patient has the right to file a written complaint to the Texas Department of Health.

All complaints are confidential.

PATIENT SIGNATURE: _____ DATE: 1/14/19

ADHESTY-K08

DISCLOSURE AND CONSENT For Medical Procedures

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (we) voluntarily request Salman Ahmad, MD / Alan Carruth, MD,

as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as:

Severe Depression Treatment Resistant

I (we) understand that the following medical procedure is planned for me and I (we) voluntarily consent and authorize this procedure: Ketamine Infusion

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician or health care provider, and such associates, technical assistants and other health care providers to perform

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

I (we) understand that serious, but rare, complications can occur with Ketamine infusions. Some of these risks are breathing and heart problems, drug reactions, nerve damage, cardiac arrest, memory dysfunction/memory loss, brain damage, paralysis, or death.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents.

DATE: 1/15/19 TIME 2:00 A.M./P.M.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON:

Signature Print Name Tiffany Young Relationship to Patient Self

WITNESS/PHYSICIAN:

Signature

PLTF 013104

ADHES TY-K09

Ketamine Clinic of North Texas, LLC
4100 Fairway Drive, Suite 200
Carrollton, Texas 75010
972-221-1741

Ketamine Treatment Discharge Instructions

Patient Name: Tiffany Young

Received on Date: 1-15-19 Time: _____

1. Do not drive or operate any machinery for the next 24 hours.

2. You must have someone accompany you outside the home for the next 24 hours.

3. Do not consume any alcohol, sedative medication or recreational drugs for the next 24 hours.

4. Do not make any important decisions or sign important documents for the next 24 hours.

5. If you have a life threatening emergency you should call 911 and/or proceed to the nearest emergency room. Please call your mental healthcare provider or primary care physician for other urgent matters.

6. If you have an urgent matter related specifically to your ketamine infusion therapy, you may call Dr. _____ Phone: _____

You will receive a follow up call within 24 hours of your treatment.

Accompanying Adult: Diane Young Date: 1/15/19

Accompanying Adult Signature: Diane Young

Patient Signature: _____ Date: 1/15/19

EXHIBIT B

STATEMENT OF QUALIFICATIONS

Advanced
DOCUMENT & HANDWRITING EXAMINATION SERVICES, LLC

Linda James, B.C.D.E., Diplomate

Board Certified and Court-Qualified

STATEMENT OF QUALIFICATIONS

EDUCATION & TRAINING

National Association of Document Examiners: Board Certified Document Examiner, Re-certified 01/01/16
National Questioned Document Association: *Forensic Document Examination Course,* 264 Study Hours
Apprenticeship/Hands-on Internship: Microscopes/Photography/Court Exhibits/Fax Machines/Printers/Copiers Typewriter/Ink Pens/Paper/Document Cases/Court/Procedures/Preparation/Testifying, over 200 Technical Hours
National Questioned Document Association: *Certified Document Examiner*, 315 Study Hours.
College Notre-Dame-de-Foy, Canada: *Introduction to Document Examination Equipmen*/45 Hrs/3 College Credits
American Institute of Applied Science: *Police Photography, Questioned Documents*
American Institute of Applied Science: *Forensic Science*, 230 Study Hours/6 College Credits/Burlington County
North Central Texas Council of Governments: Regional *Police Academy Basic Instructor Course,* 40 Hours
Total of 23 College Credits Earned and Applied Toward an Associate Degree in Criminal Justice

COURT EXPERIENCE: *See page 4 for complete list*

INSTRUCTOR

State Licensed Instructor, Texas Commission on Law Enforcement Officer Standards and Education
Texas Board of Private Investigators and Private Security Agencies/Association of Certified Fraud Examiners
First Instructor/National Questioned Document Association Document Examination Course, 1992-1997

PUBLICATIONS

2001:	*Examination of Faxed Documents*	National Association of Document Examiner Journal
1999:	*Document Manipulation*	National Association of Document Examiner Journal
1996:	*The Silent Witness*	National Association of Document Examiner Journal

BOARD POSITIONS

2017- Current:	President	*National Association of Document Examiners*
2014-2017:	Certification Chairperson	*National Association of Document Examiners*
2009-2013:	President	*National Association of Document Examiners*
2005-2009:	1st Vice President	*National Association of Document Examiners*
2000-2009:	Certification Committee	*National Association of Document Examiners*
2000-2005:	By-Laws Chairperson	*National Association of Document Examiners*
2001-2002:	Secretary	*Association Certified Fraud Examiners, Dallas, Texas*
1998-1999:	Associate Director	*Association Certified Fraud Examiners, Dallas, Texas*

PROFESSIONAL MEMBERSHIPS

Academy of Criminal Justice Sciences (ACJS), National Association of Document Examiners (NADE), Professional Member and Membership committee of Association of Forensic Document Examiners (AFDE), Texas Division of Intl. Association for Identification (IAI), Fraud Investigator's Association of Texas (FIAT), International Association of Law Enforcement Intelligence Analysts, International Association of Crime Analyst, American Society of Testing and Materials (ASTM) for the Development of Forensic Science Standards, Forensic Sciences Section (E30) Voting Member, and Questioned Documents Section (E30.02) ~Former Voting Member.

OPINIONS GIVEN ON THE FOLLOWING TYPES OF DOCUMENTS

Additions	Cut and Paste / White Outs	Forged Signatures	Medical Records
Adoption Papers	Dating Documents	Graffiti	Miranda Rights
Alleged Rape Cases	Death Threats / Threatening Letters	Hidden Writing Recovered	Photo Copies
Alterations	Diary Entries	Holographic Wills	Sequential Writing
Altered College Records	Disguised Writing	Identity Cards	Security Agreements
Anonymous Notes	Disputed Wills	Immigration Documents	Stamped Impressions
Bank Signature Cards	Divorce Papers	Indented writing	Stock Certificates
Bankruptcy	Election Ballots	Ink and Paper	Stolen Credit Cards
Birth Certificates	Embezzlement	International Cases: Kidnapping	Stolen U.S. Treasury Checks
Capital Murder Cases	Falsified Annuity Claims	IRS Documents	Toner Anchorage
Checks	Falsified Land Title Company Forms	Laser Printing Removal	Traced Signatures
Contracts	Falsified Life Insurance Forms	Lease Agreements	Typewriter
Corporate Minutes	Famous Signatures on Paintings/Books	Mail Fraud	Warranty Deeds

PRESENTATIONS

2019:	*Handwriting Forensics* – NTPA (North Texas Paralegal Association) luncheon	Dallas, TX
2018:	*Who Are You Going to Call?* -TCDLA 16th Annual Forensics Seminar	Austin, TX
2018:	*Who Are You Going to Call?* Texas Advanced Paralegal Seminar (State Bar of Texas Paralegal Division)	Addison, TX
2018:	*You See, But You Do Not Observe* - NADE Conference	Atlantic Beach, FL
2017:	*QDE Education & Training, A Tribute to Barbara Downer* - NADE Conference	New Orleans, LA
2014:	*The Silent Witness* - ACFE Dallas Chapter	Dallas, TX
2014:	*The Silent Witness* - DAPA (Dallas Area Paralegal Association)	Dallas, TX
2010:	*The Forensic Examination of a Symbolic Signature, A Case Study* -NADE Conference	Portland, OR
2010:	*Forensic Document Examination* -TCDLA 8th Annual Forensics Seminar	Dallas, TX
2008:	*Forensic Document Examination* -TCDLA 6th Annual Forensics Seminar	Dallas, TX
2008:	*E is for Evidence* -American Association of Legal Nurse Consultants	Dallas, TX
2007:	*Current Trends in Forensic Science* -Tarrant County M. E.'s Office 8th Annual Conference	Fort Worth, TX
2007:	*Instruments Employed by Document Examiners* -TCDLA 5th Annual Forensics Seminar	Dallas, TX
2007:	*A Forensic Look At Medical Records* -AORN (Assoc. of Peri Operative Registered Nurse)	Plano, TX
2007:	*Principles in Forensic Document Examinations* -TALI Super Conference	Irving, TX
2007:	*Identifying Graphic Patterns in Signatures,* Poster Presentation -NADE Conference	Tucson, AZ
2006:	*What Can a Document Examiner Do?* -TCDLA 4th Annual Forensics Seminar	Dallas, TX
2006:	*Taking Proper Request Writing Samples* -TALI Southwest Super Conference	San Antonio, TX
2006:	*The Field of Forensic Document Examination* –N. TX University Forensic Science Club	Denton, TX
2006:	*Forensic Document Examiner's Lab and Cases*, Forensic Science Class -Austin College	Sherman, TX
2005:	*Cross Examining the Document Examiner* -TCDLA 3rd Annual Forensics Seminar	Dallas, TX
2005:	*President Bush National Guard Documents and CBS* -NADE Conference	Quebec, Canada
2005:	*Business, Contract or Employment Workers for the Document Examiner* -NADE Conference	Quebec, Canada
2004:	*What is a Forensic Document Examiner?* -Plano Kiwanis Club	Plano, TX
2004:	*Science and Crime,* Forensic Science Class -Austin College	Sherman, TX
2004:	*Forensic Document Examination in the 21st Century* -TCDLA 2nd Annual Forensics Seminar	Plano, TX
2003:	*Forensic Document &Handwriting Examinations*, Forensic Science Class -Austin College	Sherman, TX
2002:	*What is a Forensic Document Examiner?* -Rotary Club Arlington Division	Arlington, TX
2001:	*Forensic Document Examination* -AICPA National Conference	Dallas, TX
2001:	*Unique Cases and Their Solutions* -Insurance Fraud Education Conference	Orlando, FL
2001:	*Unique Cases and Their Solutions* -NADE Conference	Crawley, England
2000:	*Handwriting Analysis* -Texas Association of College and University Auditors	Corpus Christi, TX
2000:	*Document and Handwriting Analysis* -Assoc. of Government Accountants Dallas Chapter	Dallas, TX
2000:	*Scientific Document Examinations* -ACFE Fort Worth Chapter	Ft. Worth, TX
1999:	*Forensic Document & Handwriting Analysis* -The Institute of Internal Auditors Dallas Chapter	Dallas, TX
1999:	*Red Flags of Forgery* -The Institute of Internal Auditors	Fort Worth, TX
1999:	*Questioned Documents & Forgery* -North Central Texas Council of Governments	Arlington, TX
1997:	*Forensic Document Techniques* -Seminar Presentation to Investigators/Peers	Dallas, TX
1997:	*Illustrating and Demonstrating Letters in Court* -NQDA Annual Conference	Dallas, TX
1997:	*Signs of Forgery* -Gateway Bank	Garland, TX
1996:	*Scientific Document Examination: What It's All About* -ACFE Dallas/Ft. Worth Chapter	Dallas, TX
1996:	*The Visible Effects of Speed in Handwriting* -Collin County Community College	Plano, TX
1996:	*Employees in the Document Examiners Office*	Dallas, TX
1995:	*How I Did It - Three Cases* -Collin County Community College	Plano, TX
1995:	*Faxes and Fraud* -NADE Conference	San Antonio, TX
1995:	*A Fingerprint in Time* -NQDA Annual Conference	Dallas, TX
1995:	*Questioned Documents* -Collin County Community College	Plano, TX

APPOINTMENTS

U. S. District Court of the Northern District of Texas, Dallas & Fort Worth Division; Bell, Bexar, Bowie, Brazos, Collin, Cooke, Dallas, Grayson, Hays, Jefferson, Lamar, McLennan, Tarrant, and Parker Counties in Texas; Wichita, Kansas; and Birmingham, Alabama.

PROFICIENCY TESTING

2001/2005/2006: NQDA and Collaborative Testing Services, Inc. *(Handwriting and Document Examination)*

CONTINUING EDUCATION

2019:	National Association of Document Examiners Annual Conference	Aberdeen, Scotland
2018:	National Association of Document Examiners Annual Conference	Atlantic Beach, FL
2017:	National Association of Document Examiners Annual Conference	New Orleans, LA
2017:	TCDLA Beating the Drum for Justice Seminar with Ethics	McKinney, TX
2016:	79th Annual Conference of the Texas Division of the International Assoc. for Identification	Galveston, TX
2016:	National Association of Document Examiners Annual Conference	Portland, OR
2015:	Association of Forensic Document Examiners Annual Symposium	San Antonio, TX
2015:	National Association of Document Examiners Annual Conference	Nashville, TN
2015:	SEAK: How to be an Effective Expert Witness	Nashville, TN
2014:	TCDLA Cross Examination Seminar with Ethics	Dallas, TX
2014:	National Association of Document Examiners Annual Conference	Honolulu, HI
2013:	National Association of Document Examiners Annual Conference	Omaha, NE
2013:	76th Annual Conference of the Texas Division of the International Assoc. for Identification	Dallas, TX
2011:	National Association of Document Examiners Annual Conference	Montreal, Canada
2011:	Institute of Graphic Communications: Introduction to Printing: technologies & consumables	Quebec Institute
2010:	FIAT & IAFCI Combined Fraud Conference	Houston, TX
2009 & 2010:	National Association of Document Examiners Annual Conference	Boca Raton, FL & Portland, OR
2008:	Association of Forensic Document Examiners Annual Symposium	Albuquerque, NM
2008:	National Association of Document Examiners Annual Conference	Austin, TX
2008:	ACFE and Institute of Internal Auditors "Focus on Fraud Prevention"	Dallas, TX
2007:	TCDLA 5th Annual Forensics Seminar	Dallas, TX
2007:	Association of Forensic Document Examiners Annual Symposium	Tucson, AZ
2007:	National Association of Document Examiners Annual Conference	Tucson, AZ
2006:	FIAT/IAFCI 2nd Annual Conference	Galveston, TX
2006:	69th Annual Conference of the Texas Division of the International Assoc. for Identification	Corpus Christi, TX
2006:	National Association of Document Examiners Annual Conference	At Sea
2005:	National Association of Document Examiners Annual Conference	Quebec, Canada
2004:	FIAT Annual Conference TCLEOSE/Austin Police Department	Austin, TX
2004:	National Association of Document Examiners Annual Conference	Anaheim, CA
2004:	American Academy of Forensic Sciences	Dallas, TX
2003:	National Association of Document Examiners Annual Conference	New Orleans, LA
2003:	Cyber Crime and Terrorism, MetroPlex	Dallas, TX
2001:	AICPA National Conference on *Fraud & Litigation Services*	Dallas, TX
2001:	64th TIAI Annual Education Conference, *Digital Photography*, Bob May (FBI)	Arlington, TX
2000 & 2001:	National Association of Document Examiners Annual Conference	Albuquerque, NM & Crawley, England
2000 & 2001:	National Questioned Document Association Educational Conference	Dallas, TX
1998:	Deloitte & Touche, *Cybercrime & Computer Forensics*/FBI Special Agents, U.S. Attorney, CFE	Dallas, TX
1998:	Assoc. of Certified Fraud Examiners, *Proving Fraud/* Master Peace Officer James D. Ratley	Dallas, TX
1998:	Criminal Justice Training Manager, Don Rabon, ACFE Fraud Examiner's Seminar	Dallas, TX
1998:	Secret Service Trained Handwriting Examiner, Chief Deputy	Denton, TX
1997:	The Forgery Investigator's Association of Texas	Georgetown, TX
1997:	National Questioned Document Association Educational Conference	Dallas, TX
1996:	National Association of Document Examiners Annual Conference	Baltimore, MD
1996:	FBI Examiner, Larry Ziegler Professional Development Seminar/*Court Testimony*	Baltimore, MD
1996:	Statement Analysis, Interviewing, & Interrogation Seminar	Dallas, TX
1996:	Academy of Criminal Justice Sciences Professional Development Seminar/*Technocrimes*/August Bequia	Las Vegas, NV
1996:	American Academy of Forensic Sciences (48th Annual Meeting)	Nashville, TN
1995:	National Association of Document Examiners Annual Conference	San Antonio, TX
1995:	National Questioned Document Association Educational Conference	Dallas, TX
1994:	American Board of Forensic Examiners	Branson, MO
1991 & 1994:	National Questioned Document Association Educational Conference	Santa Fe, NM & Kansas City, MO
1990 & 1992:	National Questioned Document Association Educational Conference	Dallas, TX

COURT EXPERIENCE (*alphabetical*)

COURT | YEAR:	LOCATION:	COURT | YEAR:	LOCATION:
2nd Judicial District Court | 2004	Albuquerque, NM	Christian Cty. Court Judicial Circuit 38 | 2015	Ozark, MO
7th Smith Cty. District Court, D.A. | 2009, 2007	Tyler, TX	Collin Cty. Probate Court No. 1 | 2007	Plano, TX
8th Judicial District Court Colfax Cty. | 2006	Raton, NM	Cty. Court No. 3 Sitting in Probate | 2009	Tyler, TX
18th Johnson City. District Court | 2006	Cleburne, TX	Dallas Cty. Court No. 3 | 2009	Dallas, TX
19th East Baton Rouge District Court | 2001	Baton Rouge, LA	Dallas Cty. Court No. 4 | 2010, 2011	Dallas, TX
27th St. Landry District Court, D.A. | 2001	Opelousas, LA	Dallas Cty. Court No. 5 | 2007	Dallas, TX
28th Nueces Cty. District Court | 2011	Corpus Christi, TX	Dallas Cty. Court No. 5a | 2018	Dallas, TX
40th Ellis Cty. District Court | 2011 DA, 2009, 2003	Waxahachie, TX	Dallas Cty. District Court | 1999	Dallas, TX
44th Dallas Cty. District Court | 2004	Dallas, TX	Dallas Cty. Probate Court No. 2 | 2011, 2006, 2004, 2003, 2003, 2002, 2001, 2001, 1997, 1995	Dallas, TX
44th Dallas Cty. Judicial District Court | 2007	Dallas, TX	Dallas Cty. Probate Court No. 3 | 2011, 2002	Dallas, TX
59th Grayson Cty. District Court | 2003	Sherman, TX	Denton Cty. District Court | 2000	Denton, TX
67th Tarrant Cty. District Court | 2000	Ft. Worth, TX	Denton Cty. Probate Court | 1997	Denton, TX
68th Dallas Cty. District Court | 2002, 2001	Dallas, TX	Fayette Cty. Probate Court | 2008	LaGrange, TX
86th Kaufman Cty. Judicial District Court | 2005	Kaufman, TX	Hopkins Cty. Court | 2001	Sulphur Spgs, TX
95th Dallas Cty. District Court | 2019	Dallas, TX	Hunt Cty. District Court | 1995	Greenville, TX
101st Dallas Cty. District Court | 2010	Dallas, TX	McLennan Cty. Court | 1997	Waco, TX
110th Floyd Cty. District Court | 2008	Floydada, TX	Morris Cty. 76-276 District Court | 2003	Dangerfield, TX
114th Smith Cty. District Court, D.A. | 2007	Tyler, TX	NASD Arbitration Hearing | 2004, 1996	Dallas, TX
116th Dallas Cty. District Court | 2007, 2005, 2001	Dallas, TX	Panola County Courthouse | 2015	Carthage, TX
121st Judicial District Court | 2007	Brownfield, TX	PUC Hearing | 2001	Austin, TX
134th Dallas Cty. District Court | 2004	Dallas, TX	Rusk Cty. Court | 2008	Henderson, TX
160th Dallas Cty. District Court | 2007, 2007, 1998	Dallas, TX	State Bar of Texas | 2000	Dallas, TX
193rd Dallas Cty. District Court | 2008, 2001	Dallas, TX	Subordinate Criminal Court | 2000	Singapore
195th Dallas Cty. Judicial District Court | 2003	Dallas, TX	Tarrant Cty. Court No. 1 | 2009	Ft. Worth, TX
199th Collin Cty Judicial District Court | 2011	McKinney, TX	Tarrant Cty. Court No. 2 | 1997	Ft. Worth, TX
203rd Dallas Cty Court | 2010	Dallas, TX	Tarrant Cty. JP Court | 1999	Ft. Worth, TX
225th Bexar Cty. District Court | 2015	San Antonio, TX	Tarrant Cty. Probate Court #2 | 2003	Ft. Worth, TX
236th Tarrant Cty. District Court | 1997	Ft. Worth, TX	TEA Independent Hearing | 2013	Dallas, TX
269th Harris Cty, District Court | 2015	Houston, TX	Texas Workforce Commission | 2007, 2004	Dallas, TX
297th Tarrant Cty. District Court | 2006, 2005	Ft. Worth, TX	Travis Cty. Probate Court No. 1 | 2015	Austin, TX
333rd Harris Cty, District Court | 2017	Houston, TX	U.S. District Court, Dallas Division | 1994	Dallas, TX
348th Tarrant Cty. Judicial District Court | 2007	Ft. Worth, TX	U.S. Bankruptcy Court, Beaumont Div. | 2007	Beaumont, TX
352nd Tarrant Cty. District Court | 2012	Ft. Worth, TX	U.S. Bankruptcy Court, Dallas Division | 1994	Dallas, TX
366th Collin Cty. District Court | 2005, 2016	McKinney, TX	U.S. Bankruptcy Court, Eastern District | 2001	Plano, TX
416th Collin Cty. Judicial District Court | 2014	McKinney, TX	U.S. Bankruptcy Court, McAllen Div. | 2008	McAllen, TX
422nd Kaufman Cty. District Court | 2005	Kaufman, TX	U.S. Bankruptcy Court, Plano Division | 2007	Plano, TX
435th Montgomery Cty. District Court | 2019	Conroe, TX	U.S. District Court -District of *Alaska* | 2004	Alaska
469th Collin Cty. District Court | 2018	McKinney, TX	U.S. District Court, Eastern & Northern District | 2004	Sherman, TX
Arbitration: Honorable Frank Sullivan | 2015	Ft. Worth, TX	U.S. Navy General Court-Martial | 2006	Pensacola, FL
Allen Cty. Court | 2002	Ft. Wayne, IN	U.S. District Court, Northern District, Dallas Division | 2013	Dallas, TX
Bell Cty. District Court | 1994	Belton, TX	Walworth Cty. Court | 1999	Elkhorn, WI
Brazos Cty. District Court | 2000	Bryan, TX	Wood Cty. District Court | 2018	Quitman, TX
Circuit Court of Nevada County | 2017	Prescott, AR	Workers' Compensation CCH | 2005	Mt. Pleasant, TX

EXHIBIT C

PRIOR EXPERT TESTIMONY

EXHIBIT C.1

PRIOR EXPERT TESTIMONY

Court Testimony

Linda James Court Testimony from 2015 to 2019

January 19, 2015	Arbitration **Honorable Judge Frank Sullivan** Attorney Lee Ann Diamond	*In the matter of the Marriage of Hollie Elaine Murphy* Cause No. 231-558967-1
May 18, 2015	County Court at Law Panola County, Texas **Honorable Judge Terry D. Bailey** Attorney Stephen C. Mahaffey	*In the matter of the Estate of Henry Twomey Boyd* Cause No. 10393
June 29, 2015	District Court, 225 Judicial District Bexar County, Texas **Honorable Judge Stryker** Attorney Danny Kustoff & Shane Bebout	*AMD Energy Services, LLC; TGFC, LLC; Gary Cain; and Shannon Smith v. FWL-AMD, LLC; FWLL, LLC; Mayra Dehoyos, Albert Dehoyos; Laura Jacobs; Stan Bates; Terica Tober; and Marcus Tober.* Cause No. 2015CI09758
July 1, 2015	Probate Court 1 of Travis County **Honorable Judge Guy Herman** Attorney Clint Alexander	*In the matter of the Estate of Nadia Gozdiff Bice* Cause No. C-1-PB-14-001802
August 11, 2015	Christian County Courts, Judicial Circuit 39, Ozark Missouri **Honorable Laura Johnson** Attorney Trent Bond	*Deutsche Bank National Trust vs. Enoch & Karen Pyle* Cause No 11CT-CC00795
November 18, 2015	In the District Court of Harris County, Texas 269th Judicial District **Honorable Dan Hinde** Attorney Jacob McBride (second chair Russell Mills)	*Distribution International, Inc., V. Synflex Insulation, LLC and Daniel Sinecio*
December 8, 2016	In the District Court of Collin County, Texas 366th Judicial District **Honorable Ray Wheless** Attorney Jennifer Justice and Scott Shanes	*Total Transportation Services LLC v. BBCS Logistics Inc. Armando Hernandez, Arin Chaghalian Haftevani, and Artin Extouni;* Cause No. 366-01945-2016

April 7, 2017	In the District Court of Harris County, Texas 333rd Judicial District **Honorable Daryl L. Moore** Attorney Andrew Scott	*Trojan Worldwide, Inc. v. Robert A. Martinez and The McAlear Group, Inc. d/b/a Service Spring Corp. d/b/a Draincables Direct*
October 3, 2017	In the Circuit Court of Nevada County, Arkansas **Honorable Judge Duncan Culpepper** Attorney Eugene Hale and David Price	*Estate of Mary Faye Stovall Preston;* Cause No. P-16-31-2
July 17, 2018	Dallas County Justice of the Peace for Precinct 2 **Honorable Judge Jerry D. Ray** Attorney Ryan K. Lurich	*O'Brian vs. Hutcheson for Justice of the Peace, Precinct 2, Place 1*
December 19, 2018	In the 469th Collin County Court **Honorable Judge Piper McGraw** Attorney Kevin T. Segler	Cause No. 469-00675-2018*; In the Matter of the Marriage of Lijuan Song and He "Frank" Chen*
December 20, 2018	In the 402nd Judicial District Court, Wood County **Honorable Judge Jeff Fletcher** Attorney Kenneth E. Raney	*Estate of Orlander Daniels, Deceased*
February 12, 2019	In the 95th Judicial District Court, Dallas County **Honorable Judge Ken Molberg** Attorney Taylor Carroll/Spencer Dieble	*2902 Maple, LP v. Calabaza Holdings, LLC, Miramar Fairmont Partners, LLC, and the City of Dallas*
February 14, 2019	In the 435th District Court, Montgomery County **Honorable Judge Patty Maginnis** Attorney ADA Shann Redwine and Brittany Litaker	*State of Texas v. Adam Lee Thomas*

EXHIBIT C.2

PRIOR EXPERT TESTIMONY

Deposition Testimony

Linda James Deposition Testimony from 2015 to 2019

February 22, 2016	417th Judicial District Court of Collin County, Texas	Cause No. 417-04422-2012 *Matthew M. McBride v. William Sellers, and Benvenuto Investment Group, Inc.*
March 22, 2016	Orinda, CA	Cause No. 1-15-PR-176711 *The Francis Living Trust; Santa Clara County Superior Court*;
March 8, 2017	United States Bankruptcy Court District of New Mexico	Case No. 16-10312-t Chapter 11 *Wallace, Debbie J. Debtor*
April 14, 2017	Probate Count No.1, Travis County, Texas	Cause No. C-1-PB-13-001901 *The Estate of James Street*
February 20, 2018	76th Judicial District Court of Titus County, Texas	Cause No. 39,314 *The Estate of Charles M. Sinclair, Deceased*

EXHIBIT D

HANDWRITING OPINION TERMINOLOGY

Scientific Working Group for Forensic Document Examination

(SWGDOC)

Standard Terminology for Expressing Conclusions of Forensic Document Examiners[1]

4. Terminology

4.1 Recommended Terms:

identification (definite conclusion of identity)—this is the highest degree of confidence expressed by document examiners in handwriting comparisons. The examiner has no reservations whatever, and although prohibited from using the word "fact," the examiner is certain, based on evidence contained in the handwriting, that the writer of the known material actually wrote the writing in question.

strong probability (highly probable, very probable)—the evidence is very persuasive, yet some critical feature or quality is missing so that an identification is not in order; however, the examiner is virtually certain that the questioned and known writings were written by the same individual.

probable—the evidence contained in the handwriting points rather strongly toward the questioned and known writings having been written by the same individual; however, it falls short of the "virtually certain" degree of confidence.

indications (evidence to suggest)—a body of writing has few features which are of significance for handwriting comparison purposes, but those features are in agreement with another body of writing.

no conclusion (totally inconclusive, indeterminable)—This is the zero point of the confidence scale. It is used when there are significantly limiting factors, such as disguise in the questioned and/or known writing or a lack of comparable writing, and the examiner does not have even a leaning one way or another.

indications did not—this carries the same weight as the indications term that is, it is a very weak opinion.

probably did not—the evidence points rather strongly against the questioned and known writings having been written by the same individual, but, as in the probable range above, the evidence is not quite up to the "virtually certain" range.

strong probability did not—this carries the same weight as strong probability on the identification side of the scale; that is, the examiner is virtually certain that the questioned and known writings were not written by the same individual.

elimination—this, like the definite conclusion of identity, is the highest degree of confidence expressed by the document examiner in handwriting comparisons. By using this expression, the examiner denotes no doubt in his opinion that the questioned and known writings were not written by the same individual.

[1] ver. 2013-2 | Wed Jan 14 13:26:05 CDT 2015 | *FOR REFERENCE ONLY*